S. HRG. 110–220

HEALTH CARE AND THE BUDGET

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

June 21, 2007—HEALTH CARE AND THE BUDGET: ISSUES AND CHALLENGES FOR REFORM
June 26, 2007—HEALTH CARE AND THE BUDGET: THE HEALTHY AMERICANS ACT AND OTHER OPTIONS FOR REFORM
September 11, 2007—HEALTH CARE AND THE BUDGET: OPTIONS FOR ACHIEVING UNIVERSAL HEALTH COVERAGE

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HEALTH CARE AND THE BUDGET: ISSUES AND CHALLENGES FOR REFORM

THURSDAY, JUNE 21, 2007

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Kent Conrad, Chairman of the Committee, presiding.

Present: Senators Conrad, Murray, Wyden, Feingold, Stabenow, Whitehouse, and Gregg.

Staff present: Mary Naylor, Majority Staff Director; Scott Gudes, Staff Director for the Minority.

OPENING STATEMENT OF CHAIRMAN CONRAD

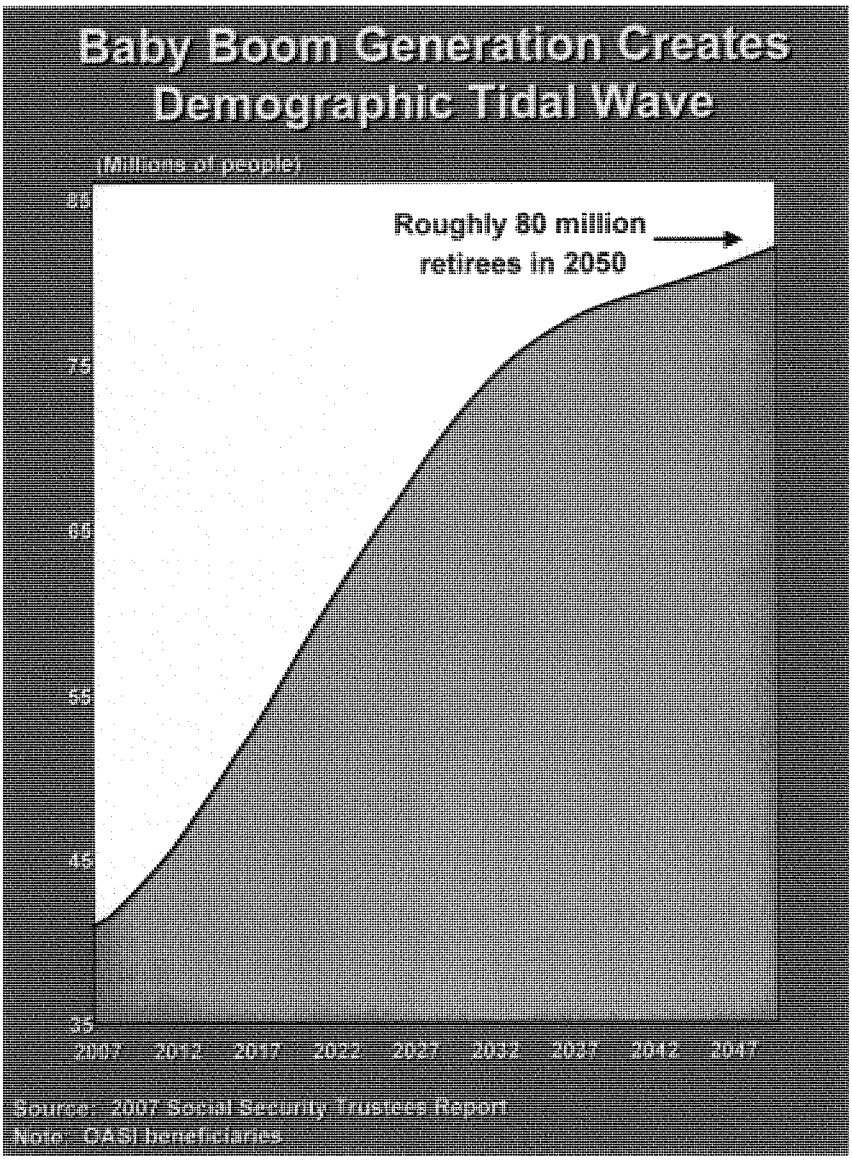
Chairman CONRAD. The hearing will come to order.

Let me just indicate we all understand the hearing room is unusually warm and the technical people are working on that. I would invite those who are here, you are welcome to take off your jackets, as it is good and warm in here this morning.

We want to welcome everyone to the hearing room this morning, the hearing on health care, with our distinguished CBO Director Peter Orszag. Dr. Orszag is particularly well-suited to address this issue. He has done an outstanding job of focusing CBO on analyzing and providing information to Congress on the problem of rising health care costs. Earlier this year he created a new panel of health advisers and he is increasing the number of CBO personnel who work on health issues over the next 2 years. That is an important and much needed change.

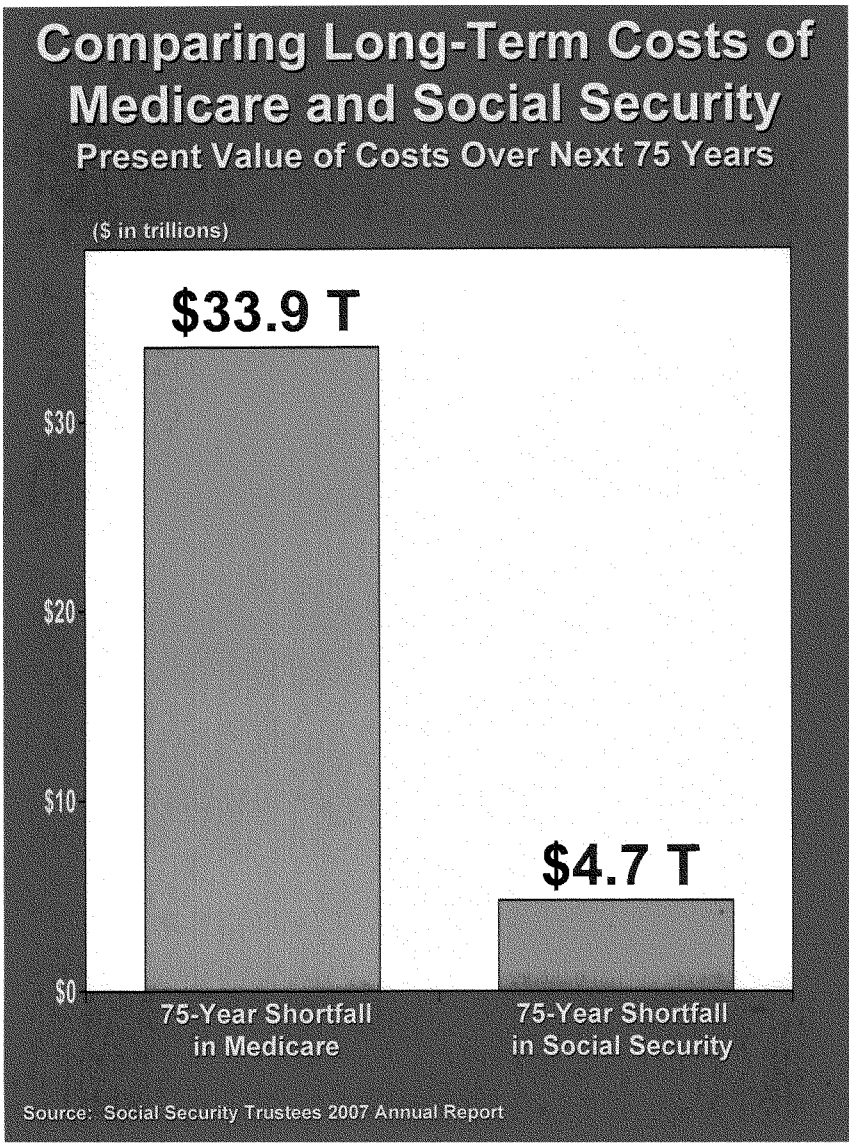
I very much appreciate Director Orszag's emphasis on this topic. I think all of us know this is the 800-pound gorilla. This is the issue that could swamp the boat for our country in terms of its fiscal future.

Let me just go to a couple of slides.

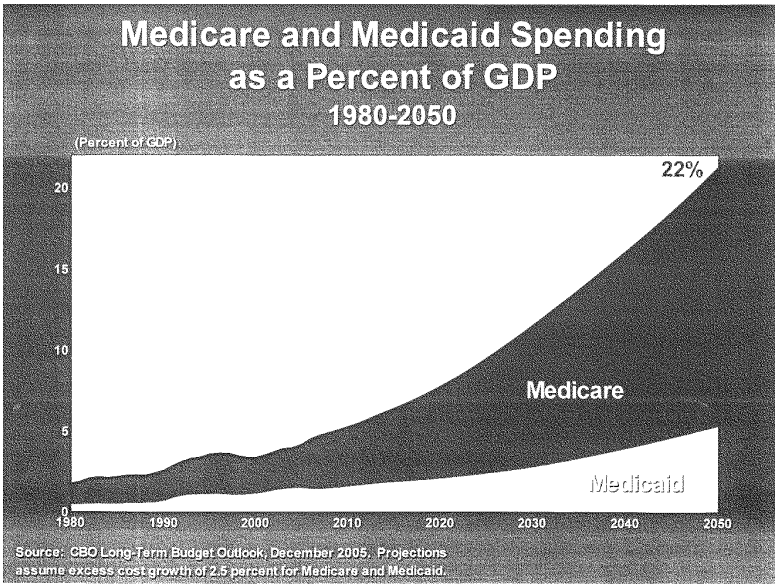

Baby Boom Generation Creates Demographic Tidal Wave
(Millions of people)
Roughly 80 million retirees in 2050
75
65
55
45
35
2007
2012
2017
2022
2027
2032
2037
2042
2047
Source: 2007 Social Security Trustees Report
Note: OASI beneficiaries

This is the driver that needs to focus our attention on the fiscal challenges facing America. We face a demographic tidal wave. We are going to have 80 million retirees by 2050, more than a doubling of the number of people eligible for Social Security and Medicare, and we need to focus on this fact like a laser.

We need to remember that Social Security is not the biggest budget challenge confronting us.

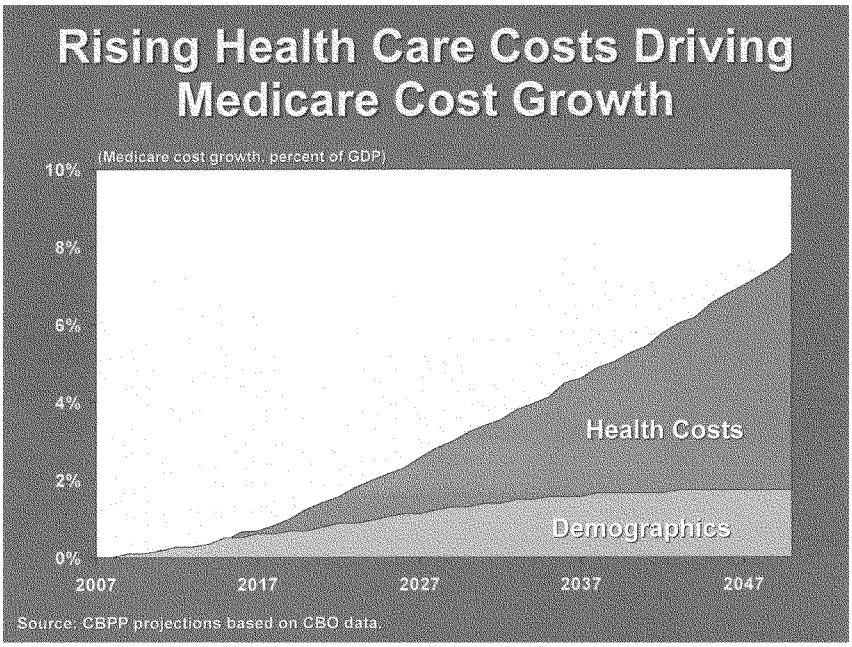

Comparing Long-Term Costs of Medicare and Social Security
Present Value of Costs Over Next 75 Years
($ in trillions)
$33.9 T
$4.7 T
$30
$20
$10
$0
75-Year Shortfall in Medicare
75-Year Shortfall in Social Security
Source: Social Security Trustees 2007 Annual Report

Because of rising health care costs and this demographic tidal wave over the next 75 years the shortfall in Medicare will be seven times the shortfall in Social Security. The growing cost of Medicare and Medicaid is simply staggering.



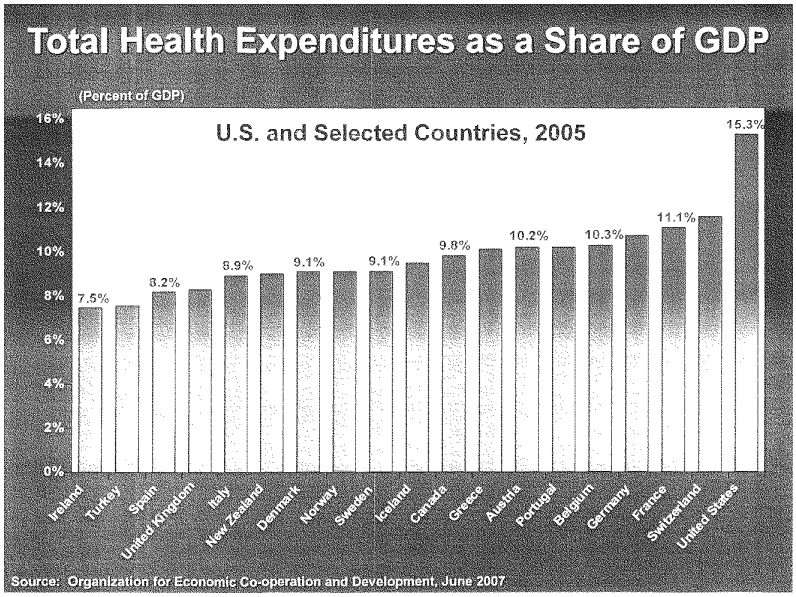
By 2050, if nothing changes, more than 20 percent of our gross domestic product will be spent on just these two programs. That is more than we now spend on the entire Federal Government. So if this does not get people's attention I do not know what will.

This next chart from the Center on Budget and Policy Priorities shows that rising health care costs are by far the biggest factor driving Medicare cost growth.


Rising Health Care Costs Driving Medicare Cost Growth
(Medicare cost growth, percent of GDP)
10%
8%
6%
4%
2%
0%
Health Costs
Demographics
2007
2017
2027
2037
2047
Source: CBPP projections based on CBO data.

Demographic changes, which I have referenced, from the retiring baby boom generation are significant but they are secondary to the rising costs.

The fact is that our health care system is not as efficient as it should be. The United States is spending far more on health care expenditures as a percentage of gross domestic product than any other country in the OECD and that includes the leading economies in the world.

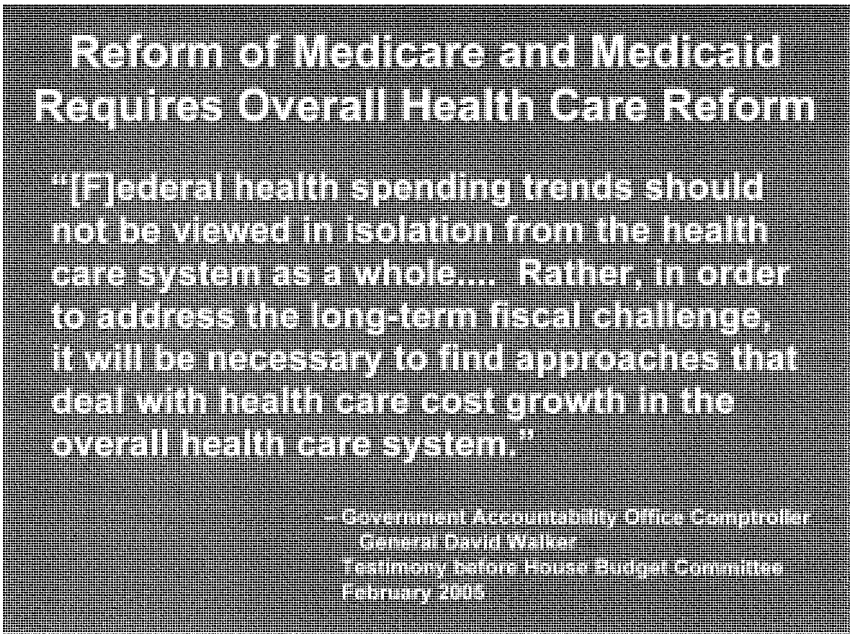


For example, the U.S. spent over 15 percent of GDP on health care expenditures in 2003 compared to 7.2 percent in Ireland. We are spending even more as a percentage of GDP today. In fact, most estimates are we are over 16 percent of GDP today on health care. That is one of every $6 in this economy going to health care.

Despite this additional health care spending, health outcomes in the United States are no better than health care outcomes in other OECD countries.

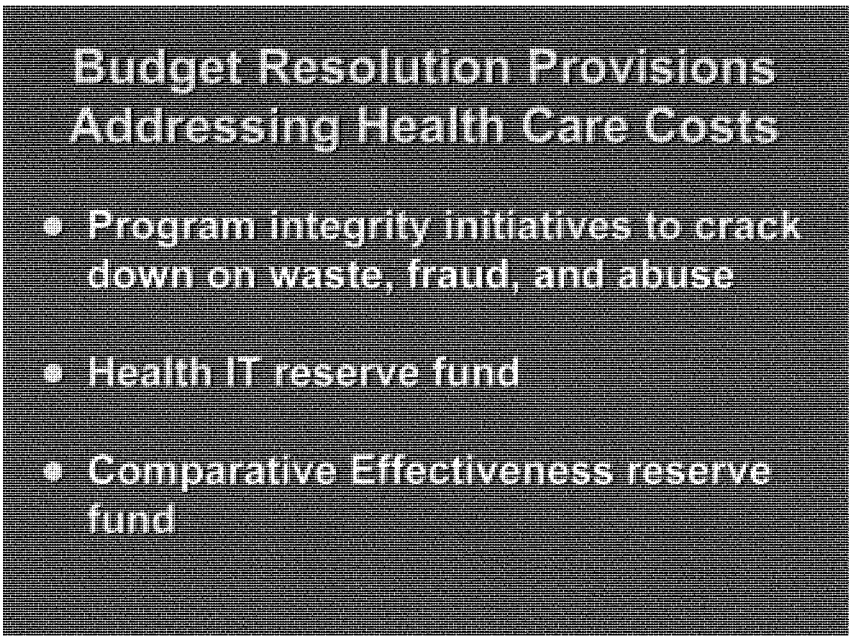
But we need to remember that the problem is not that Medicare and Medicaid are Federal programs. The problem stems from the underlying rising cost of health care.

This is a quote from the Comptroller of the General Accounting Office, General Walker, making exactly that point.



He said, and I quote "Federal health spending trends should not be viewed in isolation from the health care system as a whole...Rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system." That is a critical point.

Our budget resolution, which was adopted by Congress last month, takes a number of important steps to begin addressing these rising health care costs.


Budget Resolution Provisions Addressing Health Care Costs
• Program integrity initiatives to crack down on waste, fraud, and abuse
• Health IT reserve fund
• Comparative Effectiveness reserve fund

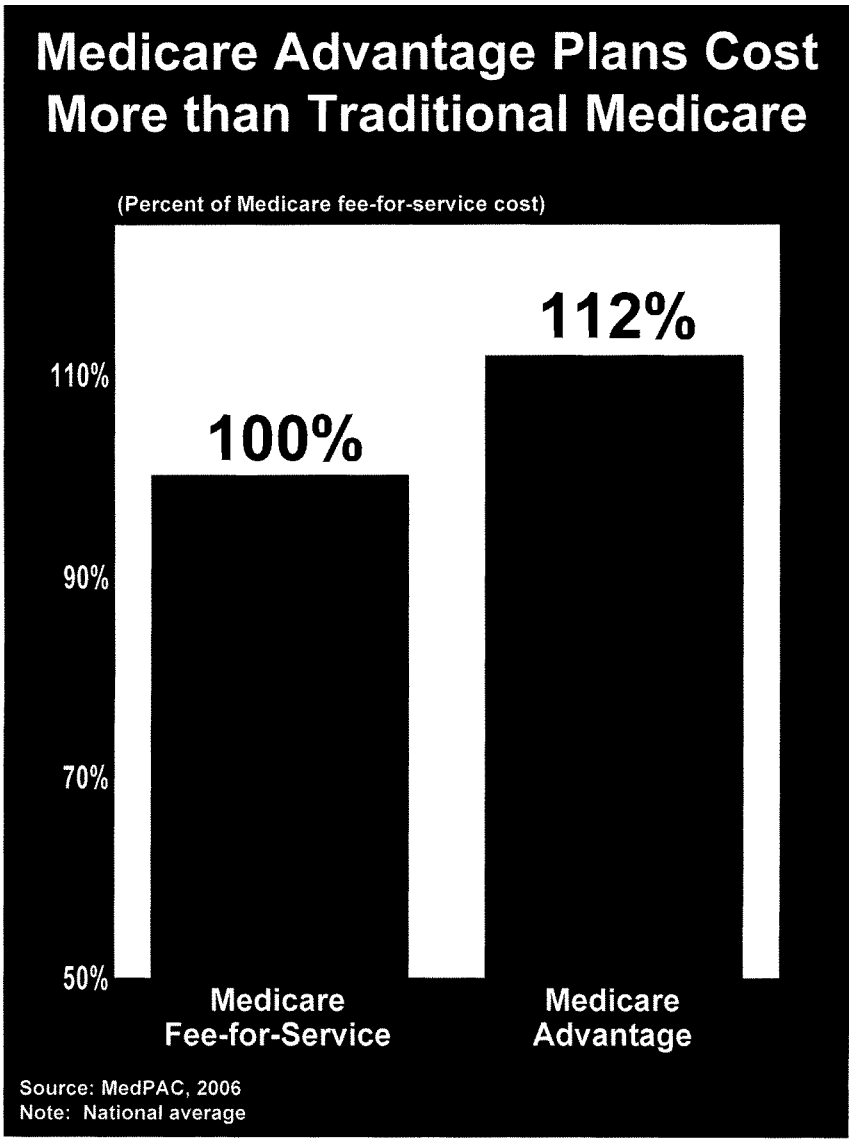
First, we include funding for program integrity initiatives to crack down on waste, fraud, and abuse in Medicare and other programs. I met with the Secretary yesterday on this issue and others and we again emphasized the importance of going after waste, fraud, and abuse in Medicare.

Second, we include a health information technology reserve fund to promote the use of advanced information technology, a point that the Senator from Michigan has made many times, Senator Stabenow. The RAND Corporation has done a study that says we could save as much as $80 billion a year if information technology were broadly deployed in health care. Additional Federal action could save even more.

Third, we include a comparative effectiveness reserve fund to jump start an initiative to provide research on the comparative effectiveness of different treatments, medical devices, and drugs. This research will lead to savings over the long term by allowing health care providers and patients to avoid treatments that may be ineffective or overly expensive while at the same time improving health care outcomes.

I would note that CBO is currently working on a study on comparative effectiveness at the request of myself and Senator Baucus, the Chairman of the Finance Committee.

In conclusion, within Medicare I believe we also need to look at the additional cost of Medicare Advantage plans.


Medicare Advantage Plans Cost More than Traditional Medicare
(Percent of Medicare fee-for-service cost)
110%
90%
70%
50%
100%
112%
Medicare Fee-for-Service
Medicare Advantage
Source: MedPAC, 2006
Note: National average

MedPAC has found that Medicare Advantage plans are costing on average 112 percent of the cost of traditional Medicare fee-for-service. These plans were meant to save money. Instead, they are contributing to Medicare's financial instability and continued growth in Medicare Advantage, similar to what we have seen recently, has major implications for future costs in the structure of the Medicare program.

At my request, CBO has done an analysis of savings if we capped Medicare Advantage expenditures at as much as 150 percent of traditional fee-for-service Medicare. And they found savings even at that level, much more significant savings if we would cap Medicare Advantage at 120 percent or 125 percent of traditional fee-for-service Medicare.

With that, I am going to turn to my colleague and able member of this Committee, Senator Gregg.

OPENING STATEMENT OF RANKING MEMBER GREGG

Senator GREGG. Thank you, Mr. Chairman. And obviously, the Chairman and I and many other members of the Senate agree on the problem, which is that we confront a demographic tsunami which is going to overwhelm our capacity as a country to support the present programs we have in place. And that if we do not do something substantive we will end up passing on to our children not only a government that is unaffordable but a lifestyle which will be significantly less in quality than the lifestyle that our generation has had because the burden which will be put on them will be so high that they will not be able to do things such as purchase homes, send their kids to college, and have discretionary spending money. It will all be spent on the government to support these programs.

But I think where the Chairman and I depart is on whether or not the Congress has responded to this. We have had innumerable hearings on this issue and they have all been good, and I congratulate the Chairman for holding this hearing. But the fact is that the numbers are there. We know them. We have been presented with them. I know that the Director is going to give us another set of numbers and some ideas. But they are not going to be significantly different than what we have already been presented before, which is that this is a problem that is huge and that is coming at us and that cannot be avoided as were reflected in the Chairman's numbers.

I think to refer to the last budget as having taken a bite out of this apple is really an exaggeration which cannot be defended by the facts. The simple fact is that we have not, as a Congress, stepped in to this issue. The President, ironically, put forward a proposal, a very legitimate proposal, which would have used reconciliation to address the issue of health care and the out-year cost of health care.

The unfunded liability of Medicare is approximately $32 trillion. Under the President's proposal that unfunded liability would have been reduced by almost 25 percent. And his proposal would not have affected present beneficiaries or future beneficiaries of middle and moderate income, or low income for that matter. It would have

primarily affected the top 5 percent of Medicare beneficiaries who have high incomes.

It had two basic elements: first, that reimbursements to providers should be accurately paid and should not be inflated. And they are, by all estimates, and especially by the independent analysis, inflated by the extent of about 1.3 percent which is benefit accruing from more technological capability and efficiencies within the system. And what the President suggested was to let the provider groups keep half of that inflated payment but have the other half be returned to basically make the system more solvent.

The second proposal was to have high income retirees pay a larger proportion of the costs of their premiums so that a person, a retired member of the Senate, or Warren Buffett's Part D premium for Medicare drug benefit is not subsidized by working Americans who are working at a garage or on an industrial line or at a restaurant.

Today average working Americans trying to make ends meet, trying to raise families, trying to send their kids to college, trying to make their payments, are also paying the cost of Warren Buffett's Part D drug benefit. And they are paying the costs of retired members of the Senate's Part D drug benefit which is totally inexcusable. There is no reason those premiums should not be means-tested, wealth-tested.

And the proposal the President suggested was reasonable. He said if an individual makes more than $80,000 or a couple more than $160,000, then they should pay a larger portion of their drug benefit costs. Both of those ideas were rejected, rejected out of hand by the Democratic budget.

But worse than that, because those were reasonable ideas that did not have any partisan policy to them, in fact I would think that coming from the other side of the aisle there would be some receptiveness to taxing—not taxing, but making people who have high incomes pay the fair cost of their Part D premium.

Worse than the fact that they were rejected was there was no alternative put forward. The President suggested a proposal to take $8 trillion of potential unfunded liability out of the system. The response from the other side of the aisle was to reject that, to reject having high income people pay a larger part of their Part D premium, to have a more accurate reimbursement for provider groups. But no substitute, nothing was brought forward to substitute.

In fact, not only was nothing brought forward to address it but the situation was dramatically aggravated by the use of reconciliation as a vehicle to dramatically expand the Government. We just saw that occur yesterday in the HELP Committee where the reconciliation instructions were used for the purposes of increasing spending 2,500 percent more than savings were put in place for deficit reduction. $1 billion of savings, $20 billion of new spending used by—and reconciliation was used as the vehicle to accomplish that.

So instead of having reconciliation, which is supposed to be a vehicle that controls the rate of growth of entitlements in this Government, it was used as a vehicle to expand entitlements and there was no attempt in the Democratic budget—in fact, it was rejected on the floor—to address the funding and the correction of Medicare.

In addition, we know that the issue of how you correct Medicare is an issue of utilization, transparency, and access to quality, reasonable cost health care. We know from studies that have been done at the Dartmouth Institute for Health Policy and Clinical Practive that if you look at the cost and utilization and quality of health care across this country you will find that in many States, especially for example I will take Florida, utilization is high, cost is high, and outcome is not that good for Medicare recipients.

If you look at a state like say Washington State, I—utilization is low, cost is low, and outcomes are higher, are better.

And so we know, we know what we need to do. And I know Dr. Orszag is going to tell us again what the problem is. I am not sure he is going to tell us what we need to do. We know what we need to do. The problem is we do not have, as a Congress, the courage to do it. It is that simple.

So I appreciate the hearing. I appreciate more information being brought to the table. But I do think there is a legitimate disconnect to represent that the last budget in any way significantly moved us down the road toward solving the first set of charts which were reflecting the problem.

Chairman CONRAD. Let me just take a minute to respond because the Senator has raised a number of issues that are legitimate to raise but deserve a response.

First of all, I went through in some detail in my opening statement things that were in this budget to address these long-term challenges. The fact is, as I have stated on many occasions, I do not believe the budget resolution is the place where these long-term entitlement challenges can be successfully addressed. But we did take a series of important steps. First of all, by providing a health IT reserve fund. As I have indicated, the RAND Corporation says that if we deployed information technology broadly in our society we could save over $80 billion a year.

And second, a comparative effectiveness fund to deploy the best and most cost effective methodologies.

We also know that that would provide tremendous savings. So those provisions are in the budget.

Why didn't we address the long-term entitlement challenges? Very simply because I do not believe that you will ever resolve those in a budget resolution. That is going to take a separate negotiation between the White House and the Congress. Why not a budget resolution? Well first of all, the President plays no role in a budget resolution. But a president will have to play a central and significant role in addressing our long-term imbalances in Medicare and Social Security.

So the irony is Senator Gregg and I talked just as recently as yesterday about introducing a proposal that would create a process that would address these long-term imbalances in a bipartisan way, a working group that would be given the responsibility to come back with a plan, a plan that would involve not only the Congress but the White House.

I think it is going to take that kind of bipartisan approach that involves directly the White House to have any hope of dealing with these long-term imbalances.

Senator GREGG. If I could just quickly respond, Mr. Chairman.

First, I do not in any way—in fact, I do not wish my opening statement to imply in any way—question the desire and purpose of the Chairman to address this issue. And his commitment here is legitimate and I know it is substantive and I know he wants to get to this point. I know that he is limited by the ability he has to get votes on his side of the aisle.

But I do have to say that I think my characterization of the budget was accurate. But more importantly than that, the President is a player in the budget process. And when he becomes a player is on reconciliation. He has to sign the reconciliation bill. So where the budget process can drive this exercise is when we give reconciliation instructions that force the committees of jurisdiction to take action. That is when we can drive the process.

Unfortunately, I think the thing that I find most upsetting is that the only reconciliation instruction given was not the one that the President suggested, which is to make wealthy people pay a larger part of their Part D premium or to get their reimbursements right for provider groups. It was a reconciliation instruction which yesterday was used to expand the government by 2,500 percent over what it saved in deficit reduction.

And so I do think we missed an opportunity and I will leave it at that.

Chairman CONRAD. Let me just conclude this by saying I do not think we have missed an opportunity. I do not think the budget resolution that is just carried on one side of the aisle—there were only two Republican votes for the budget. In the House just a handful there, as well.

So to deal with these long-term challenges is truly going to take a bipartisan effort. The fact is the President does not have a role in a budget resolution. The budget resolution never goes to the president. It is purely a Congressional document.

To deal with the long-term entitlement challenges is going to take the direct involvement of the President of the United States and going to take the direct involvement of the Congress of the United States.

Let me also, in terms of reconciliation and what was included in the budget, first of all it did not expand government by 2,500 percent. That is not the case. What it did was provide an ability to extend higher education reauthorization using the reconciliation process but one that is completely paid for, completely paid for. Plus it will produce about $1 billion of deficit reduction.

Now that is not inappropriate. That is what reconciliation is for. I might say when our colleagues controlled the budget process they used reconciliation not to reduce the deficit, which is the only legitimate purpose for reconciliation. They used reconciliation, which is a fast track procedure that goes outside the normal rules of the Congress, to explode the deficit and the debt. They have added trillions of dollars of debt using reconciliation. We have not, by the use of reconciliation on our side, expanded the deficit by a dollar. Instead, we have used it to reduce the deficit and at the same time extend higher ed reauthorization, which is going to mean more affordable college for hundreds of thousands of Americans, which is absolutely essential to our continued position in the world. If we are not first in education, we are not going to be first in anything.

With that I want to turn to Dr. Orszag for his opening statement.

I want to acknowledge the important role that Senator Wyden has played in this hearing and hearings to follow. And I think all of us, one place that we agree is the need for a bipartisan approach to what really is the 800-pound gorilla, dramatically rising health care costs.

Welcome, Dr. Orszag.

STATEMENT OF PETER R. ORSZAG, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. ORSZAG. Thank you very much.

Mr. Chairman, ranking member Gregg, other members of the Committee, my testimony this morning focuses on several points, the most important of which is that when it comes to the Nation's long-term fiscal health, we have been misdiagnosing the problem. The central long-term fiscal challenge facing the United States is rate at which health care costs grow relative to the economy, as my first chart shows. Is that chart up? Thank you.

That chart shows the path of Medicare and Medicaid expenditures as a share of GDP if, over the next four decades, health care costs grow as rapidly compared to income per capita as they did over the past four decades, those two programs would rise from 4.5 percent of the economy today to more than 20 percent by 2050, which is the entire size of the Federal Government today.

The bottom dotted line shows you what happens if health care costs track income per capita. It isolates the pure effect of aging on those two programs. Here is the point. I think you can see that where you wind up in 2050 under that bottom dotted line is higher than where you start today, but that that difference is way smaller than the difference in 2050 between the bottom dotted line and the top point.

In other words, to a first approximation the Nation's long-term fiscal challenge collapses to the rate at which health care costs grow compared to income per capita. That is the key variable.

Rising health care costs represent a challenge for the budget but also for the private sector, which is not surprising because the same forces that are driving up costs in the public sector are driving up costs in the private sector, including the spread of new technologies and changes in cost-sharing requirements.

If you look over long periods of time, as figure two shows, costs per beneficiary in Medicare and Medicaid have tracked costs per beneficiary in the rest of the health system. That is very likely to occur in the future and therefore sustainable changes to Medicare and Medicaid will only work if they are accompanied by other changes that restrain overall health care cost growth.

In light of that, though, I would note that a very significant opportunity exists to reduce costs because the evidence suggests that more expensive care need not mean higher quality care. Perhaps the most compelling evidence of that opportunity comes from the significant geographic variation in Medicare costs per beneficiary which this chart shows.

In reference to a comment that was made earlier by Senator Gregg, I would note that the Senators in this room all come from

the light States where costs are lower than in other parts of the country. In fact, in many States costs are lower than in other countries. The reasons cannot be explained by the underlying risk characteristics of the patients. They cannot be explained by the costs of building hospitals or wage rates in the lighter areas. And the kicker is that the darker areas, were higher spending occurs, do not generate better health outcomes than the lower spending regions, as my next chart shows.

If you look at a simple correlation across States of spending versus quality, there is no correlation that exists. One of the reasons for that is that a lot of spending occurs without any evidence associated with it. The Institute of Medicine has suggested that only about a quarter of health care costs have any evidence associated with them. So the vast bulk of what we are doing in health care is not backed by medical evidence in terms of whether it works better than something else. As a result, you get a lot of variation in cost that does not translate into better quality.

Chairman CONRAD. Let me just stop you on that point so we rivet that point. Let us not have anybody miss that point.

What you are saying is more spending does not result in better health care outcomes.

Mr. ORSZAG. That is correct. And that represents a very substantial opportunity. It is going to be difficult to capture, but to take cost out of the system without harming health. So embedded in this central long-term fiscal challenge facing the United States is an opportunity to take costs out of the system without harming health. And I think moving toward capturing that opportunity is most important objective that policymakers could pursue if you are interested in achieving long-term fiscal balance.

And by the way, it is the same problem that private employers are facing with the rising cost of health care in the rest of the health system. The kind of variation that I showed you for Medicare also exists in Medicaid and it exists in the rest of the health system also.

Chairman CONRAD. So this goes beyond Medicare and Medicaid. It is endemic in the health care system, that more expenditures do not result in better health care outcomes.

Mr. ORSZAG. Within the United States I think there is a wide variety of evidence suggesting that at the margins more expenditures do not seem to generate better health outcomes. And the amount of money that we are talking about is very significant.

Just as an example, and without embracing the specific estimate, the Dartmouth group that Senator Gregg mentioned before has suggested that if you move the darker regions of the country, if we go back to the earlier slide, the darker regions of the country toward practice norms and practice patterns and medical practices that are like the lighter parts of the country, you could reduce overall health care costs by 30 percent without harming health.

You can do the math. We are currently spending——

Chairman CONRAD. Reduce health care costs by 30 percent?

Mr. ORSZAG. 3–0. We are currently spending 16 percent of GDP on health care. You do the math. We are talking about a lot of money.

In light of that, I think it is very important again to emphasize the variation is larger often where there is no evidence on what works and what does not. So for example, if you fracture your hip it is very clear what is going to happen. You are going to be hospitalized. You are in intense pain. You are usually going to go in for surgery. There is not that much variation in the cost of inpatient hip fracture cases.

Once you get out of the hospital, however, there is no evidence, should you go back and see the doctor five times a month, twice a month? Should you get an MRI or not? Should you do physical therapy or not? No one knows.

Post-hospitalization costs vary a lot. And I think the reason is that there is no evidence of what works and what does not. Doctor norms in different parts of the country vary. And because they are not backed by hard evidence, they do not generate better health outcomes.

That opens up an obvious opportunity which is to expand the share of health care costs with which there is some evidence associated. So Senator Conrad, as you mentioned, the interest in comparative effectiveness research, basically looking at what works and what does not, is precisely aimed at trying to build out or increase the share of health care costs where there is some evidence on what works and what does not. And then practitioners and patients could use that information to move toward higher value health care rather than paying for things and doing things that might not be generating any better outcomes.

I think we have to really ask the question why some parts of the country are able to deliver quality health care at so much lower rate cost than other parts of the country and be delving into ways to try to narrow that variation is one mechanism for addressing this opportunity to reduce costs without harming health.

A second opportunity is that if you look over long periods of time, as figure four shows, there has also been a very significant reduction in cost-sharing requirements. So out-of-pocket expenses as a share of total health care costs have decreased significantly over the past three or four decades. With, in 1975, out-of-pocket expenses accounting for about a third of health care expenditures and today it is nearing 15 percent.

The evidence suggests that those lower out-of-pocket expenses put upward pressure on overall health care costs and another opportunity would be to work on the demand side of the health care equation by increasing the cost sharing that each individual has. I think it is very important, it might sound like that is a higher burden. But when we each individually have a lower out-of-pocket cost sharing requirement, it drives up overall costs and we all wind up paying for that higher level of expenditures which might not wind up generating better health.

There is also evidence from randomized experiments that have been done with variations in cost-sharing requirements that when you increase, perhaps even modestly, cost-sharing requirements on individuals the result is lower quantities of health care consumed but no adverse consequences in general, on average, for health.

So operating on both sides of the equation, the supply side in terms of the information that is provided and perhaps the incen-

tives that providers are given, and then on the demand side in terms of providing information to consumers and also perhaps changing their financial incentives, are the two sides of the scissors that would help to reduce costs over the long term.

I agree with Senator Gregg, there are many things that can be done. But I would also argue that there are many things that we do not know yet, in particular again because the share of health care costs with which there is evidence associated is so small, the challenge in moving toward creating incentives toward higher value health care is significant because in many cases we just do not know what works and what does not.

So that was the main theme of my testimony. I also covered a variety of other topics ranging from employer-sponsored insurance to uninsurance to the importance of prevention and healthy living. I am not sure if you want me to cover those topics now or move right to questions because I know that I have spent a significant amount of time just going over that most important topic, Mr. Chairman.

[The prepared statement of Mr. Orszag follows:]

CBO TESTIMONY

Statement of
Peter R. Orszag
Director

Health Care and the Budget: Issues and Challenges for Reform

before the
Committee on the Budget
United States Senate

June 21, 2007

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CONGRESSIONAL BUDGET OFFICE
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Chairman Conrad, Ranking Member Gregg, and other Members of the Committee, thank you for inviting me to testify this morning on the U.S. health care system and the major budgetary and policy issues associated with that system. Rising health care costs and their consequences for federal health insurance programs constitute the nation's central fiscal challenge. Rising costs also represent a critical issue for employers—who sponsor most private health insurance coverage—and for the enrollees and patients who ultimately bear the costs of health insurance and health care. At the same time, substantial concerns exist about the number of individuals who lack health insurance, about the quality of care that is provided both to the uninsured and to the insured, and about trends in health such as the growing prevalence of obesity.

In light of those challenges, my testimony today makes four main points:

- **Health Care Costs.** The nation's long-term fiscal balance will be determined primarily by the future rate of health care cost growth. If health care costs continued growing at the same rate over the next four decades as they did over the past four decades, federal spending on Medicare and Medicaid alone would rise to about 20 percent of gross domestic product (GDP) by 2050—roughly the share of the economy now accounted for by the entire federal budget. Furthermore, controlling those federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise. A variety of evidence, however, suggests that opportunities exist to constrain health care costs both in the public programs and in the rest of the health care system without adverse health consequences. Capturing those opportunities to reduce costs without harming health outcomes involves many challenges, including the time that may be necessary to generate significant savings—but even if reforms take time to generate savings, acting sooner rather than later can ultimately make a substantial difference.

- **Employer-Sponsored Insurance.** Most Americans get their primary health insurance through an employer—either their own or that of a family member. Many employers have expressed serious concerns about rising health care costs; to date, however, aggregate data indicate that any reductions in employers' offers of insurance or the scope of coverage they provide have been modest. An employer-based system has both advantages (for example, workers' risks are pooled together) and disadvantages (for example, workers often have to change their health plan when they change jobs). A key issue for broad health reform proposals is whether they are based upon an employer-sponsored system: if so, whether they retain the significant existing tax incentives for employer-based insurance, and if not, how they create

the pooling mechanisms essential for effective health insurance markets.

- **Lack of Insurance.** The most recent estimates indicate that about 45 million people were uninsured at any given point in 2005. Both the high cost of health care and the evolution of employer-based health insurance affect the number of people who have coverage. Higher premiums discourage people—especially those who have lower income and who perceive themselves as healthy—from purchasing insurance. People who are not employed or who choose to work at a firm not offering insurance may have to seek coverage in the individual market, where policy terms and tax benefits are generally much less attractive than those for employer-sponsored plans. Federal and state expansions of coverage over the past 25 years—particularly through Medicaid and the State Children's Health Insurance Program (SCHIP)—have significantly reduced uninsurance rates among eligible populations. Many proposals aim to reduce the number of uninsured further, through either direct spending or tax credits, but such proposals typically generate budgetary costs that must ultimately be financed by higher revenues or offset by lower spending elsewhere—and almost invariably cause at least some substitution of public funds for private funds.

- **Prevention and Healthy Living.** The ultimate objective of the health care system is to improve health. Despite the resources that the nation devotes to treating diseases, the results in terms of health gains are mixed, and many investments that can foster better health—such as preventive medicine—are underused. At the same time, various types of unhealthy behavior—such as smoking, poor diets, and a lack of regular exercise—remain relatively common. Although proposals that encourage more prevention and healthy living can help to promote better health outcomes, their effects on federal and total health spending are uncertain.

Rising Health Care Costs

Over the past four decades, Medicare's and Medicaid's costs per beneficiary have increased about 2.5 percentage points faster per year than has per capita gross domestic product (GDP).[1] If those costs continued growing at the same rate over the next four decades, federal spending on those two programs alone would rise from 4.5 percent of GDP today to about 20 percent by 2050 (see Figure 1); that amount would represent roughly the same share of the economy as the entire federal budget does

1. See Congressional Budget Office, *The Long-Term Budget Outlook* (December 2005), pp. 6–7 and 31–32.

today. If, instead, those costs grew at the same rate as income—a scenario that illustrates the pure effect of demographic changes on the two programs—then the change in spending by 2050 would be much smaller. Indeed, that change would be substantially smaller than the difference between the two scenarios. That observation underscores that the rate at which health care costs grow relative to income is the most important determinant of the long-term fiscal balance; it exerts a significantly larger influence on the budget over the long term than other commonly cited factors, such as the aging of the population.

Rising health care costs represent a challenge not only for the federal government but also for private payers. Indeed, the trends for both largely reflect the same underlying forces—the spread of costly new medical technologies, limited cost-sharing requirements, and other factors—and cost growth per beneficiary in Medicare and Medicaid has tracked that in the rest of the health system over long periods of time (see Figure 2). Total health care spending, which consumed about 8 percent of the U.S. economy in 1975, currently accounts for about 16 percent of GDP, and that share is projected to reach nearly 20 percent by 2016. About half of that spending is now publicly financed, and half is privately financed.

Reasons for Cost Growth and the Relationship Between Cost and Quality

In order to see what options may exist to limit future cost growth, it is useful to review the main factors contributing to that growth—as well as past efforts at cost control. Many analysts attribute the bulk of the growth in health care spending to the development and diffusion of new medical technology, or, as one leading observer has described it, "the increased capabilities of medicine."[2] Recent medical advances have made a wealth of new medical therapies available to physicians and patients. Some advances permit the treatment of previously untreatable conditions, which can confer substantial benefits but also introduces new categories of spending. Others advances may improve medical outcomes (compared with those provided by older treatments) but at added costs. Some studies have found that the spread of new medical technology has yielded benefits that clearly justify the added costs on average, but other evidence also strongly suggests that additional treatments and services are being provided broadly to patients who could do just as well with less-expensive care.[3]

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2. Joseph P. Newhouse, "An Iconoclastic View of Health Cost Containment," *Health Affairs*, vol. 12, Supplement (1993), pp. 152–171.

3. See David M. Cutler, *Your Money or Your Life: Strong Medicine for America's Health Care System* (New York: Oxford University Press, 2004).

Significant evidence exists that more-expensive care need not mean higher-quality care—suggesting an opportunity to reduce costs without impairing health outcomes. Perhaps the most compelling evidence of that opportunity comes from the substantial geographic differences in spending on health care within the United States—and the fact that they do not translate into higher life expectancy or measured advantages in other health statistics in the higher-spending regions.[4] For example, Medicare's costs per enrollee vary significantly from regions to region: from as low as $4,000 to more than $11,000 in 2003 (see Figure 3). Research has shown that much of that variation in spending cannot be explained by differences in the population or medical prices and that the higher-spending regions do not generate better health outcomes than the lower-spending regions.[5] Furthermore, differences in spending are not correlated with measures of the quality of care that enrollees receive (see Figure 4). Concerns about that regional variation are buttressed by the fact that hard evidence is often unavailable about which treatments work best for which patients or whether the added benefits of more-effective but more-expensive services are sufficient to warrant their added costs—and in many cases, the variation in treatments is greatest for those types of care for which evidence about relative effectiveness is lacking.

Another important factor affecting the level and potentially the growth rate of health care costs is the manner in which insurers reimburse and oversee the delivery of health care. Up through the 1980s, private health insurance coverage in the United States typically took the form of an "indemnity" policy, which reimbursed enrollees for their incurred costs, left it to them and their doctors to determine what care to provide, and largely allowed doctors and hospitals to set prices for those services. Rapidly rising health costs and concerns about the incentives that those arrangements provided led to increased enrollment in managed care plans, such as health maintenance organizations. Those plans used various methods to reduce both the prices and the quantity or intensity of health care services, including limited networks of providers and requirements to obtain a referral from a primary care physician in order to see a specialist. Their adoption played an important role in controlling U.S. health care costs

4. Comparisons among countries also support that conclusion. For a recent comparison of health spending and outcomes in the United States and other countries, see McKinsey Global Institute, *Accounting for the Cost of Health Care in the United States* (San Francisco: McKinsey & Company, January 2007).

5. See John E. Wennberg, Elliot S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs,* Web Exclusive (February 13, 2002), pp. w96–w114; and Elliot S. Fisher and others, "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 38, no. 4 (February 18, 2003), pp. 273–287.

during the 1990s. Private payments for health care grew at the same rate as the overall economy between 1992 and 2000, and total spending for health care as a share of GDP remained constant at about 14 percent between 1993 and 2000. By the end of the 1990s, however, the increasing objections of enrollees and providers to the constraints of managed care—which often included restrictions on treatments that were not based on medical evidence—led health plans to adopt less aggressive forms of management and produced shifts in enrollment toward more loosely managed plans. Fee-for-service reimbursement remains the predominant form of payment in private health insurance as well as Medicare.

Spending is the product of prices and quantities, so concerns about rising health care costs also raise questions about the prices that are paid for services. Measuring prices in the health sector can be difficult, however, both because it can be hard to control for changes over time in the quality of the products being compared (which makes historical price comparisons misleading) and because discounts negotiated by private insurers are typically confidential. Despite those challenges, some observers have suggested that, properly measured, many prices for health care have actually grown at rates comparable to general inflation and that prices have not played a substantial role in the growth of U.S. health costs over time.[6]

Even so, price levels affect total spending, and in some cases private insurers may have difficulty negotiating low prices for health care items and services—whereas public purchasers have sometimes intervened to obtain relatively low prices. In the case of doctors and hospitals, limited competition in some parts of the country acts as a constraint on private negotiations; in the case of prescription drugs, public policy (through patents) gives manufacturers monopoly power—which leads to higher drug prices but also encourages the development of new drugs that can be patented. Federal and state purchasers have established mechanisms that yield prices that are below private-sector levels for drugs (under Medicaid and the health program for military veterans) and for doctors and hospitals (under Medicare and particularly Medicaid), but such approaches can also raise various concerns (including concerns about access to providers).

Another important factor that both reflects and has contributed to rising health costs is the declining proportion of those costs that are paid out of pocket. Out-of-pocket payments accounted for 33 percent of all personal health care expenditures in 1975, but by 2005, that share had fallen to 15

6. See David M. Cutler and others, "Are Medical Prices Falling? Evidence from Heart Attack Treatments," *Quarterly Journal of Economics*, vol. 113, no. 4 (November 1998), pp. 991-1024; and Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* vol. 6, no. 3 (Summer 1992), pp. 3–21.

percent (see Figure 5). It is projected to decline a little more in the future, reaching 13 percent in 2015. Consumers facing lower out-of-pocket costs tend to demand more health care services than consumers facing higher out-of-pocket costs. At the same time, rising health care costs (as a share of income) have probably led individuals to seek more extensive insurance in order to keep the variability of their out-of-pocket expenses from increasing.

Options for Controlling Health Care Costs

A number of programmatic changes within Medicare and Medicaid, including changes in payments to providers and eligibility rules, could be implemented to reduce federal spending.[7] Those options have different implications for overall health spending, however. Some would simply result in a reallocation of total costs among different sectors (the federal government, the corporate sector, households, and state and local governments) rather than a reduction in overall costs; others would involve some combination of shifting among sectors and reduction in total costs; and still others would reduce both federal and total health spending in parallel. Many analysts believe that significantly constraining the growth of costs for Medicare and Medicaid over long periods of time, while maintaining broad access to health providers under those programs, can occur only in conjunction with slowing cost growth in the health care sector as a whole.

Ultimately, therefore, restraining costs in Medicare and Medicaid requires restraining overall health care costs. Two potentially complementary approaches to reducing total health spending—rather than simply reallocating spending among different sectors of the economy—involve generating more information about the relative effectiveness of medical treatments and changing the incentives for providers and consumers in the supply and demand of health care.

The current financial incentives facing both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if evidence about their effectiveness relative to existing therapies is limited. For doctors and hospitals, those incentives stem from fee-for-service reimbursement. Such payments can encourage health care providers to deliver a given service in an efficient manner but also provide an incentive to supply additional services—as long as the payment exceeds the costs of the services. For their part, insured individuals generally face only a portion of the costs of their care and, consequently, have only limited financial incentives to seek a lower-cost treatment—a

7. See Congressional Budget Office, *Budget Options* (February 2007); and Statement of Donald B. Marron, Acting Director, Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs,* before the Senate Special Committee on Aging (July 13, 2006).

trade-off inherent in having insurance protection. Private health insurers have incentives to limit the use of ineffective care but are also constrained by a lack of information about what treatments work best for which patients.

Many analysts believe that expanded research on "comparative effectiveness" offers a promising mechanism to address some of those concerns.[8] Analysis of comparative effectiveness is simply a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients. Such studies may compare similar treatments, such as competing drugs, or they may analyze very different approaches, such as surgery and drug therapy. The analysis may focus only on the relative medical benefits and risks of each option, or it may go on to weigh both the costs and the benefits of those options. In some cases, a given treatment may be found more effective for all types of patients, but more commonly a key issue is determining which specific types would benefit most from it. An expanded research effort could be organized in various different ways. In response to a request from the Senate Budget and Finance Committees, the Congressional Budget Office (CBO) will issue a report on those options in the near future.

Comparative effectiveness research could be facilitated by having more health records available in electronic form, assuming privacy concerns were appropriately addressed.[9] That format makes it easier to collect detailed data on the health status and the clinical characteristics of patients, which in some cases could be used to compare treatments in a rigorous way without having to conduct full-scale clinical trials. Indeed, despite somewhat exaggerated claims about direct cost savings from investments in health information technology, one reason those investments might have a long-term impact on health costs is because of their potential to expand and improve comparative effectiveness research.

To affect medical treatment and reduce health care spending, the results of comparative effectiveness analyses would ultimately have to change the behavior of doctors and patients—that is, to get them to use fewer services or less intensive and less expensive services than are currently projected. Bringing about those changes would probably require action by public and

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8. For an analysis of the issue, see Statement of Peter R. Orszag, Director, Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role,* before the Subcommittee on Health, House Committee on Ways and Means (June 12, 2007).

9. See Jean R. Slutsky, "Moving Closer to a Rapid-Learning Health Care System," *Health Affairs,* Web Exclusive (January 26, 2007), pp. w122-w124; and related articles in that issue on rapid learning and electronic medical records.

private insurers to incorporate the results into their coverage and payment policies in order to affect the incentives facing doctors and patients.

Although private insurers could choose not to cover drugs, devices, or procedures that were found to be less effective or less cost-effective, the insurers would have a number of additional options as well. They could simply provide more information to patients and doctors, which could improve compliance with treatment guidelines. Alternatively, insurers could adjust payments to doctors and hospitals to encourage the use of more-effective care. Or insurers could require enrollees to pay some or all of the additional costs of more-expensive treatments that were shown to be less effective or less cost-effective (in which case enrollees would have to decide whether the added benefits were worth the added costs). Indeed, some recent proposals call for "value-based" insurance design that encourages the use of services when the clinical benefits exceed the costs and likewise discourages the use of services when the benefits do not justify the costs.[10] Although insurance plans generally vary cost sharing by the type of service provided—with lower cost-sharing requirements for hospital care and higher obligations for outpatient services—that new approach would be tailored to the patient and the treatment.

The Medicare program has not taken costs into account in determining what services are covered and has made only limited use of comparative effectiveness data in its payment policies—but if statutory changes permitted it, Medicare could use information about comparative effectiveness to promote higher-value care. For example, Medicare could tie its payments to providers to the cost of the most effective or most efficient treatment. If that payment was less than the cost of providing a more expensive service, then doctors and hospitals would probably elect not to provide it—so the change in Medicare's payment policy would have the same practical effect as a coverage decision. Alternatively, enrollees could be required to pay for the additional costs of less effective procedures (although the impact on incentives for patients and their use of care would depend on whether and to what extent they had supplemental insurance coverage that paid some or all of Medicare's cost-sharing requirements).

More modest steps that Medicare could be authorized to take would include smaller-scale financial inducements to doctors and patients to encourage the use of cost-effective care. Doctors and hospitals could receive modest bonuses for practicing effective care or modest cuts in their payments for using less effective treatments. Likewise, enrollees

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10. Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, "Value-Based Insurance Design," *Health Affairs,* Web Exclusive (January 30, 2007), pp. w195–w203.

could be asked to pay a portion of the additional costs of less efficient procedures (rather than the full difference in costs). Or Medicare could provide information to doctors and their patients about doctors' treatment patterns, which would create some pressure for doctors to use more-efficient approaches. Adopting more modest measures to incorporate the findings of comparative effectiveness research, however, is likely to yield smaller savings for the program.

Even in the absence of more information about comparative effectiveness, changes in incentives could help to control health care costs—but such measures would be more likely to maximize the health gains obtained for a given level of spending if they were combined with improved information. On the provider side, greater bundling of payments to cover all of the services associated with a treatment, disease, or patient could reduce or eliminate incentives to provide additional services that might be of low value. Such approaches, however, can raise concerns about the financial risk that providers face and about their incentives to provide too little care. On the consumer side, a landmark health insurance experiment by RAND showed that higher cost sharing reduces spending—particularly when compared to a plan offering free care—with little or no adverse effects on health.[11] However, compared with more typical health insurance plans (which do not offer free care), high-deductible designs have more modest effects on health care spending; such approaches also raise concerns about the financial burden on individuals with more health problems (again reflecting trade-offs between providing insurance protection and maintaining incentives to control costs).[12]

The broad options of generating more information and of changing incentives do not represent an exhaustive list of proposals intended to reduce health costs. Some analysts have advocated significant expansions of disease management and care coordination as mechanisms for reducing costs—proposals that reflect the increasing prevalence of many chronic conditions, the large share of health care spending that is incurred by individuals with those conditions, and lack of care coordination systems in many public and private health insurance plans. The top 25 percent of Medicare beneficiaries, for example, account for 85 percent of Medicare costs (see Figure 6), and more than three-quarters of those expensive beneficiaries had one or more of seven prominent chronic conditions (including coronary artery disease, diabetes, and congestive heart

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11. See Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251–277.

12. See Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006).

failure).[13] However, the evidence to date—including the findings of several demonstration projects conducted under Medicare—suggests that disease management and care coordination may raise the quality of health care provided but do not significantly reduce costs among a broad array of patients.[14] As more empirical evidence on the approaches develops, identifying specific ways to reduce costs, especially for targeted subsets of beneficiaries, may become possible; for now, the possibility and scope of savings remain unclear. In future months and years, CBO will be expanding its work to provide the Congress with more analysis of various options for controlling health care costs.

Whichever approaches are taken, the overall impact of steps to control costs will be greater the sooner that they are taken—particularly if they reduce the growth rate of health care costs and not just the level of those costs. For example, if costs per beneficiary in Medicare and Medicaid grew 1 percentage point faster than per capita GDP starting in 2025—rather than growing at the long-term historical rate of 2.5 percentage points faster—then the share of the economy devoted to those two programs in 2050 would shrink by nearly 7 percent of GDP, from 21 percent to about 14 percent (see Figure 7). If that slower growth rate were instead obtained starting in 2015, the projected spending for those programs in 2050 would be reduced by nearly 9 percent of GDP (from 21 percent to about 13 percent).[15]

In considering those potential savings, it is important to note that they are merely illustrative and do not represent CBO's estimates of the effects that any specific proposal or combination of options would have. As the

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13. See Congressional Budget Office, *High-Cost Medicare Beneficiaries* (May 2005).

14. See Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs* (October 13, 2004); Randall Brown and others, "The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years," (Mathematica Policy Research, Inc., March 21, 2007), available at www.mathematica-mpr.com/publications; and Statement of Stuart Guterman, Senior Program Director, Program on Medicare's Future, The Commonwealth Fund, *Enhancing Value in Medicare: Chronic Care Initiatives to Improve the Program,* before the Senate Special Committee on Aging (May 9, 2007).

15. Similarly, if costs per enrollee continued to grow 2.5 percentage points faster than per capita GDP, the present value of Medicare and Medicaid spending over the next 50 years would equal almost 11 percent of the present value of GDP over that period. If that difference in growth rates were reduced to 1 percentage point starting in 2025, the present value of outlays would decline to about 9 percent of GDP. And if the slower growth rate were obtained starting in 2015, the present value of outlays would fall to about 8 percent of GDP.

challenges touched on in the preceding discussion suggest, reducing the growth rate of health costs over an extended period of time will be a complicated endeavor.

Employer-Sponsored Insurance

Concerns about the operation of private insurance markets have given rise to various proposals that seek to improve the efficiency of those markets and that could also affect health care spending. Because of the central role that employer-sponsored coverage currently plays, a key issue for broad health reform proposals is whether they are based upon an employer-sponsored system, and if not, how they create the pooling mechanisms essential for effective health insurance markets. Other key budgetary and policy issues include any requirements for employers' contributions and the treatment of existing tax subsidies for employer-sponsored insurance.

Issues with Current System

Most Americans get their primary health insurance through an employer—either their own or that of a family member. By CBO's estimates, 165 million nonelderly individuals are currently covered by employer-based insurance, with 140 million obtaining that coverage through a large or medium-sized employer (one with 50 or more workers) and 25 million obtaining that coverage through a small employer. Although employer-based insurance has advantages, particularly when provided through a larger employer, that arrangement also has limitations, and many employers have expressed serious concerns about the rising costs of providing coverage. Employers' concerns are presumably a proxy for the underlying issue, which is how well the employer-based system functions for the American public: Ultimately, workers pay for their coverage directly or through reduced wages, and the advantages and disadvantages of that system accrue to them.

One advantage of employer-based insurance is that it can facilitate the pooling of risks. Although employees will vary in their use of health services from year to year, the average health costs of a large group of employees tend to be quite stable—because higher-than-expected costs for some workers are offset by lower-than-expected costs for others. As a result, employees can be offered insurance that reduces their exposure to high medical costs without posing substantial financial risks for their employer (and, indeed, many large employers choose to assume those risks themselves rather than contracting with an insurance company to bear them). Employers typically foster risk pooling by offering to cover a majority of the total premiums; even though a firm's workers (as a group) ultimately pay for that subsidy, employers' contributions lower the price of insurance that individual workers see and thus encourage broad participation. Another advantage of employer-based coverage is its

reduced administrative costs—compared with those that would be incurred if employees purchased their own policies in the individual insurance market—which in turn lower the premiums.

At the same time, several concerns about employer-based coverage have been raised. For one, the advantages related to risk pooling and administrative costs are less evident for smaller firms, which employ about one-fourth of all workers. As a result, premiums for small employers are typically higher (for the same level of coverage) and can also be more volatile—factors which contribute to the lower likelihood that small employers offer insurance. In addition, the link between employment and insurance coverage typically means that when workers change jobs, they also have to change their insurance plan. Over time, the resulting turnover of enrollees may discourage insurers from subsidizing health investments that take a long time to pay off, because the initial insurers may not be the ones to realize the benefits from them. Finally, other observers object to the limited range of choices provided by many employers—at least a third of workers have no choice of health plan—and to the role that employers play in selecting which types of coverage are made available (even though over the long term, employers' offerings presumably evolve to reflect the collective preferences of their workers).

Another key feature of the U.S. health care system is that insurance purchased through employers receives favorable treatment under the tax code—which encourages enrollment in such coverage but also tends to drive up health costs. Employers may deduct the costs of providing that coverage as a business expense (just as they deduct employees' wages and other forms of compensation), and thus those payments avoid corporate taxes on profits. But unlike wages, the costs that employers pay for health insurance are excluded from the taxable income of the policyholders (and most employee contributions are similarly excluded). As a result, that portion of employees' compensation avoids individual income and payroll taxes as well. For a typical worker, those tax preferences amount to a subsidy from the government of more than 30 percent toward the costs of health care services covered by employer-sponsored insurance. By reducing the price of that insurance, the tax subsidy also encourages workers to secure more extensive policies through their employers, increasing the share of costs that is covered and decreasing the share that is paid out of pocket. In turn, that more extensive coverage puts upward pressure on total health spending.

Rising health costs in recent years have generated concerns that employers will cease offering coverage or make their coverage less comprehensive. However, aggregate data indicate that such effects have been modest to date. The share of workers who have employer-sponsored health insurance has decreased somewhat since 2000, but according to surveys of

employers, that development largely reflects a decline in the percentage of smaller firms that are offering insurance; coverage rates at larger firms have fluctuated over time but were comparable in 2000 and 2006.[16] There is also some evidence that in recent years, employment has shifted somewhat to smaller firms and to industries that are less likely to offer coverage. Even with the recent decline in smaller firms' rates of offering insurance, their overall "offer rate" remains comparable to that in 1996.

Amounts that enrollees have to pay out of pocket in premiums and cost-sharing have risen significantly in absolute terms, but for the most part those increases are in line with rising health costs overall. On average, the share of health costs that enrollees pay directly has not changed much (and the longer-term trend in the share of health care paid out of pocket, as indicated above, has been a substantial decline). Between 2000 and 2006, employees' average contributions to health insurance premiums—the amount they pay directly, net of any employers' contributions—rose about 85 percent. The overall costs of their insurance plans rose about 75 percent over that same period, yielding only slight changes in the share of premiums paid directly by enrollees.

Options for Reforming Employer-Sponsored Insurance

Proposals to replace or significantly modify the current system of employer-sponsored insurance vary widely in their design. Some would establish a single-payer system in which all workers and dependents would participate, as under proposals to allow or require all individuals to enroll in Medicare. Others would move in essentially the opposite direction, shifting to a system in which insurance was typically purchased in the individual market (perhaps accompanied by additional regulation of that market). Still others would build on the existing employment-based system but use subsidies or mandates to increase the number of workers and dependents who had insurance, such as "pay or play" proposals that would require most employers either to offer health insurance or to contribute to a fund that would subsidize insurance purchases.

A full analysis of those options is beyond the scope of my testimony today, but a few key considerations can be highlighted. One is the impact each option might have on the pooling of risks. By their nature, single-payer systems pool all participants together. By contrast, options that emphasize the individual insurance market may require further regulation—such as limits on the degree to which premiums may vary and on the factors (such as age) that may affect premiums—to maintain current levels of pooling, as most supporters of such options recognize. In

16. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Annual Survey* (Washington, D.C., September 2006).

principle, all enrollees in a given insurer's policy are pooled together even though they purchased their coverage individually. In practice, however, those who have health problems will generally find changing insurers or plans more difficult, so, over time, as healthier enrollees gravitate toward less expensive policies, the degree of pooling that occurs will tend to decline.

Another significant issue involved in any reform of the employer-provided system is the short- and medium-term impact on employers' contributions to health insurance. Over time, any changes in those contributions, which are substantial, should be reflected in workers' wages or other benefits, but the speed of that adjustment could vary. Alternative systems for employers' payments—including new taxes or other mandatory contributions—could also have significant macroeconomic effects on incentives to work and on the formation and organization of businesses (if, for example, contributions were tied to the size of firms). The specific effects of any proposal, however, would depend importantly on the details of the new system that would be established.

A closely related question is whether proposals modify or repeal the tax exclusion for employer-sponsored insurance. Replacing the tax exclusion for employment-based health plans with a deduction or tax credit that could be used in either the employment-based or individual market would make employment-based plans less attractive (relative to individually purchased plans) than they are now. As a result, the number of people insured through employment-based plans would decline. Although some of the people losing coverage in the employment-based market would become uninsured, the bulk of them would be insured through the individual market instead. Moving from the current system—in which the tax exclusion creates a bigger tax subsidy for larger health insurance expenditures—to a fixed deduction or credit independent of the cost of a health plan would cause people to buy plans with less extensive benefits, on average.[17]

Lack of Insurance

The most recent estimates available indicate that about 45 million individuals lacked health insurance at any given point in 2005; a larger number were uninsured at some point during that year.[18] In some respects,

17. For an analysis of the President's proposal to create a standard tax deduction for health insurance, see Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008* (March 2007), pp. 57–62.

18. For a discussion of different measures of the uninsured population, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

the uninsured are a heterogeneous group: Some are young and healthy and may not perceive a need to purchase health insurance, while others are older and have health problems that make insurance expensive to obtain. Many of the uninsured lack coverage for a relatively short time, but others are chronically uninsured.

Even so, a common characteristic of the uninsured is that they tend to have low income. Depending on whether the analysis looks at all uninsured or is weighted toward those with longer spells, the share of the uninsured who live in families with income below 200 percent of the poverty level is between two-thirds and three-quarters. Studies also indicate that about 80 percent of the uninsured live in families with at least one worker (usually with a full-time job). In most cases, however, those workers are either employed by firms that do not offer health insurance, or they are not eligible to enroll in the health insurance plans that their employer offers.

Factors Affecting the Number of Uninsured

Both the high cost of health care and the evolution of employer-based health insurance affect the number of people who have coverage. Higher premiums discourage people from purchasing insurance—especially those who have lower income or who perceive little risk of incurring a costly illness. (Rising health care costs can also make insurance protection more valuable, but that consideration may not substantially affect the behavior of lower-income or younger and healthier people.) Those who are not employed or who choose to work at a firm not offering insurance—and who do not have coverage through a spouse's policy—have to seek insurance in the individual market, where policy terms and tax benefits are generally much less attractive than they are for employer-sponsored plans. As a result, many such people (and their family members) are uninsured.

Federal programs have reduced significantly the number of people who would otherwise be uninsured. The Medicare program provides nearly universal coverage to the elderly, a substantial share of whom lacked health insurance (or had very limited coverage) at the time of its enactment. Medicaid offers health insurance coverage to a variety of low-income individuals—primarily poor children and their mothers, pregnant women, the disabled, and the elderly. In 2006, about 30 million nondisabled children in low-income families were enrolled in Medicaid. At the same time, surveys indicate that several million people are eligible for Medicaid and otherwise uninsured but not enrolled in the program. Such individuals may simply be unaware of Medicaid or their eligibility for it, or they may be dissuaded from enrolling by various factors, including the stigma that is sometimes associated with means-tested programs. In many cases, individuals may be enrolled into Medicaid when they need expensive services; thus, those who are eligible for but not

enrolled in the program have some protection against financial loss but do not obtain the full benefits of participation.

The State Children's Health Insurance Program (SCHIP), enacted in 1997, also provides health insurance coverage to uninsured children living in families with income that is relatively low—but too high to qualify for Medicaid. During 2006, nearly 7 million children were enrolled in SCHIP at a total cost to the federal government of about $5 billion.[19]

SCHIP has significantly reduced the number of low-income children who are uninsured. CBO estimates that, among children living in families with income between 100 percent and 200 percent of the poverty threshold, the uninsurance rate fell from 22.5 percent in 1996 (the year before SCHIP was enacted) to 16.9 percent in 2005, a reduction of 25 percent. In contrast, the uninsurance rate among children in higher-income families remained relatively stable during that period (see Figure 8). As with Medicaid, estimates indicate that a substantial number of children are eligible for SCHIP but not enrolled in it. Although SCHIP and Medicaid have significantly reduced the number of uninsured children in low-income families, the net effect on the extent of coverage is smaller than the number of children who have been enrolled in public coverage because the increase in public coverage has been partially offset by a reduction in private coverage.

Concerns about the uninsured include the financial risk they face and the prospect that their health will be adversely affected. According to one recent study, people who are uninsured for a full year receive about half as much care as continuously insured individuals—partly reflecting the fact that many uninsured individuals are relatively young and healthy but also a result of the higher costs they face for services.[20] Several studies have found that, when they have a serious disease, the uninsured are less likely to have received a prompt diagnosis of their condition and are less likely to receive expensive treatments.[21] The majority of the care that the uninsured do receive is provided free of charge or at a substantially reduced cost, either because they receive services from clinics or other

19. See Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007). The figure for the number of people enrolled in 2006 reflects enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of that total.

20. Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs*, Web Exclusive (February 12, 2003), pp. W3-66–W3-81.

21. For a review of those studies, see Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academy Press, 2002), available at www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf.

sources that are subsidized by the government or because private providers are unable to collect payment.

To address such concerns, several states have taken or are contemplating their own initiatives targeting the uninsured. For example, Massachusetts enacted a program in 2006 aimed at providing nearly universal health insurance coverage for its residents. The legislation generally requires individuals to purchase insurance and includes increasing penalties for those who do not obtain coverage (in 2008, they will have to pay roughly half of the cost of the least expensive health plan offered in their region); additional penalties apply to employers who do not offer coverage. To make it easier for individuals without access to employer-based plans to obtain coverage, an insurance exchange (known as the Connector) has been established. To help lower-income individuals obtain coverage, the state will fully subsidize insurance for those with income below 150 percent of the poverty level and will offer smaller subsidies to those with somewhat higher income. Even so, some individuals have been exempted from the coverage mandate because they have been deemed unable to find low-cost sources of coverage. Other states, including California (which has a much larger uninsured population), are considering similar approaches.

Options for Expanding Insurance Coverage

Although reductions in overall health costs would tend to lower health insurance premiums—and thus could reduce the number of people without insurance—a substantial number of people were uninsured even when health care costs were lower. Substantially reducing the number of uninsured individuals would therefore probably require a mandate to purchase insurance (or similar penalties for not having coverage), a set of subsidies for low-income people, or some combination of those approaches. The share of people who are uninsured tends to decline as their income rises, so subsidies of premiums could be set on a sliding scale. A tradeoff exists in the size of the subsidy: larger subsidies would increase voluntary purchases of insurance but would also be more costly to provide. A mandate to purchase insurance combined with a penalty for not doing so also provides an impetus to obtain coverage, but in the form of a stick rather than a carrot.

Subsidies could take the form of tax rebates or credits or direct support through a government program like Medicaid (in which the enrollee's premiums cover less than the average cost of the policy). Because the uninsured tend to have lower income and therefore face lower marginal income tax rates, tax credits tend to be a more effective means of providing subsidies than tax deductions (whose value increases with the marginal tax rate). For the same reason, tax credits are even more valuable to low- and moderate-income recipients if they are refundable, because

that feature makes the full value of the credit available even if it exceeds recipients' income tax liability. An inevitable trade-off is that providing new government subsidies to expand insurance coverage will displace some private spending—because it is difficult to prevent people with low-income who already have health insurance from qualifying for the newly offered subsidies.

Here too a full consideration of the advantages and disadvantages of those options would require much more extensive analysis than can be presented in this testimony, but a few key points can be covered regarding administrative costs and overall health care costs. Administrative costs could be affected if options for expanding insurance coverage also included reforms of the individual insurance market (as discussed above in connection with changes to the employer-sponsored insurance system) as well as mechanisms to oversee the insurance policies offered and to facilitate enrollment in a plan (as under the Massachusetts initiative). Insurance market reforms have the potential to reduce or eliminate some administrative costs now incurred by private insurers. For example, community rating requirements—under which all enrollees pay the same premium, at least within an age range—or limits on the factors that can be used to adjust premiums could reduce costs that insurers now incur to enroll beneficiaries and underwrite their policies. At the same time, providing information and conducting outreach to individuals involves administrative costs that may be difficult to avoid under any system that provides a choice of insurance plans. Administrative costs could be reduced further under a single-payer system, but trade-offs would arise between achieving those savings, running the plan efficiently, and limiting choices for enrollees.

Several factors would affect the overall impact that expanding insurance coverage would have on total health care spending—first and foremost being the net increase in coverage and the type and extent of insurance provided. Health spending associated with individuals who were newly covered would be expected to increase because coverage would encourage greater use of services (indeed, that would be one of the objectives of expanding coverage). A shift in measured spending would also occur, because the services used by newly covered beneficiaries would be paid for by their insurer rather than becoming uncompensated care. Some of that increase would be offset by reductions in government spending that now goes to provide free or subsidized care, and it is also possible that reductions in uncompensated care could reduce costs for other private payers (if doctors and hospitals lowered their fees to private insurers as a result of receiving higher payments on behalf of formerly uninsured individuals). The extent of such effects is highly uncertain, however.

Prevention and Healthy Living

The ultimate objective of any health care system is to promote health, whether by treating diseases that arise or by preventing them from occurring in the first place. Despite the cost of the nation's health care system, many concerns exist about the degree to which it is attaining that objective. Indeed, concerns about rising health care costs might not be so prominent if more evidence showed that those expenditures were yielding commensurate gains in health. In part, those shortcomings in the system's performance relate to the questions noted above about whether patients are receiving the most effective or most cost-effective treatments—reflecting a lack of information, among other factors. Concerns also exist, though, about steps that are *not* being taken today to prevent the onset of disease, even when clear evidence is available about their benefits. In that context, proposals that encourage more prevention and healthy living can help to promote better health outcomes, although their net effects on federal and total health spending are uncertain. Moreover, bringing about substantial changes in behavior could require actions outside the formal health care sector, and even then might be very difficult to achieve.

Issues Regarding Preventive Care and People's Behavior

The health of the American public, on average, is lower than it could be because steps that can foster better health—such as preventive medicine—appear to be underused, and various types of unhealthy behavior—in particular, those contributing to recent increases in obesity—remain relatively common.

Preventive services encompass several distinct types of care: immunizations and other interventions that actually prevent diseases from arising; screening tests that can determine the presence of a disease; and counseling to encourage healthy behavior or discourage unhealthy habits. The U.S. Preventive Services Task Force, an arm of the Department of Health and Human Services, has analyzed the cost-effectiveness of many preventive services and has developed a recommended list of interventions that should be routinely provided. (In some cases, the evidence necessary to make a recommendation is not available—a situation analogous to the uncertainties about which treatments work best.) According to one study, however, adults receive only about half of the recommended preventive services.[22]

Various reasons have been cited for the low use of preventive services, including a lack of awareness about their benefits among consumers and a

22. See Elizabeth A. McGlynn and others, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, vol. 348, no. 26 (June 26, 2003), pp. 2635–2645. That study also found that adults receive about half of the recommended services for acute and chronic health problems.

focus on treatment rather than prevention among doctors. Another source of concern has been the extent to which insurance plans cover preventive care and the cost-sharing requirements for that care. The majority of private insurers appear to cover immunizations and various screening tests—and about half of the plans that require a deductible exempt at least some preventive services from it—but coverage of counseling services is much more limited; low reimbursements to physicians for counseling services also discourage their provision.[23] Coverage of preventive care under Medicare requires specific legislative authority, and thus varies from services to service. Medicaid covers childhood immunizations on a consistent basis, but coverage for screening and diagnostic services for children and adults varies from state to state. To address that situation, some health researchers have recently put forward proposals to expand the use of preventive care using federal subsidies.[24]

Such steps could improve health, but the net effect of greater use of preventive care on health spending is uncertain. In some cases, preventive care can help avoid more costly treatments that may be required after a disease has developed further. In other cases, though, increased use of preventive care could increase other health care spending—to treat newly discovered diseases or to address complications arising from testing, for example. Additional costs are associated with treating people who have received "false positives"—that is, who are incorrectly identified as having a given disease. Furthermore, screening tests are typically performed on people with no symptoms, so the number of people tested may be quite large compared with the number who will have a disease discovered. As a result, one older study found, the use of preventive care usually adds to overall medical spending, once the cumulative costs of screening individuals who are found not to have the disease in question are included.[25] A more recent review of the evidence concluded that, "with the exception of some immunizations, most preventive services do not 'save' money."[26] The extent to which electronic health records and other information technology advances could allow more precise targeting of screening tests remains unclear.

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23. See Eileen Salinsky, *Clinical Preventive Services: When Is the Juice Worth the Squeeze?* Issue Brief No. 806 (Washington, D.C.: National Health Policy Forum, August 24, 2005); and Kaiser Family Foundation, *Employer Health Benefits: 2006 Annual Survey.*

24. See, for example, Jeanne M. Lambrew, *A Wellness Trust to Prioritize Disease Prevention*, Hamilton Project Discussion Paper 2007-04 (Washington, D.C.: Brookings Institution, April 2007).

25. Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, D.C.: Brookings Institution, 1986).

26. Salinsky, *Clinical Preventive Services*, p. 7.

Perhaps an even more important determinant of health than the health care system is an individual's behavior. In particular, obesity and smoking have substantial health consequences.

Obesity. The share of Americans who are overweight or obese has risen dramatically over the past three decades, from about one-half to roughly two-thirds—with the share who are obese accounting for the entire increase (see Figure 9). According to one recent study, the rise in obesity rates in the United States is related mostly to an increase in caloric intake—and in particular, an increase in calories from snacks—rather than a decline in caloric expenditures—that is, reduced activity.[27]

Obesity is associated with many serious medical conditions, including diabetes, heart disease, and high blood pressure. According to another recent study, obese people incurred medical costs in 2001 that were 37 percent higher than those for people of normal weight—a difference of about $1,000 per person.[28] That study also found that the increased prevalence of obesity between 1987 and 2001 accounted for 12 percent of the overall growth in real (inflation-adjusted) medical spending per capita that occurred over that period. Another study found even more significant implications for Medicare: The share of spending attributable to obese enrollees increased from about 9 percent in 1987 to about 25 percent in 2002, a substantially larger increase than was seen in the obesity rate for the Medicare population.[29]

Smoking. Smoking rates have declined in the United States, but roughly one-fifth of the population still smokes. Smoking rates among pregnant women have also shown a steady decline, but about 10 percent of expectant mothers still smoke despite the substantial health risks that smoking poses to their babies (see Figure 10).

Smoking rates began to fall following the Surgeon General's 1964 report on smoking, which stated definitively that smoking causes cancer. Since that time, additional information about the adverse health effects of smoking has been developed and disseminated—which has probably contributed to the steady decline in smoking rates. (For example, smoking

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27. David M. Cutler, Edward L. Glaeser, and Jesse M. Shapiro, "Why Have Americans Become More Obese?" *Journal of Economic Perspectives*, vol. 17, no. 33 (Summer 2003), pp. 93–118.

28. Kenneth E. Thorpe and others, "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, Web Exclusive (October 20, 2004), pp. W4-480–W4-486.

29. Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (June 2007), p. 9.

is associated with a significantly increased risk of developing heart disease and emphysema and of having a stroke) Other factors affecting smoking rates are regulations such as bans on smoking in certain areas and limits on how cigarettes can be sold and, more importantly, the rise in the real price of cigarettes. Federal excise taxes and most state taxes on tobacco have been raised periodically over the years, and those increases are passed on to consumers, boosting the retail price of cigarettes. Each 10 percent increase in price, research has shown, causes the use of cigarettes to fall by 2.5 percent to 5 percent.

In general, the fact that taxing an item can cause consumers to buy less of it than they might otherwise can result in a less efficient allocation of society's resources (unless some of the costs associated with the taxed item are not reflected in its price). But the use of cigarettes creates "external costs" for society that are not paid by smokers or tobacco producers, such as higher costs for health insurance (to cover the higher medical expenses incurred by smokers) and the damaging effects of cigarette smoke on the health of nonsmokers. Furthermore, people may underestimate the harm they do to themselves by smoking or the addictive power of nicotine. Teenagers in particular may not be capable of evaluating the long-term effects of beginning to smoke. For reasons that are not entirely clear, the smoking rate for teens (which had been comparable to the rate for adult men) increased in the early 1990s. But that rate fell substantially following the significant increases in cigarette prices that accompanied a multibillion-dollar settlement agreement between major tobacco companies and the states.

Options Regarding Prevention and Healthy Living

Reform proposals could encompass preventive measures and efforts to encourage healthier lifestyles. Broadly speaking, three basic policy approaches could be adopted. First, more information about the consequences of unhealthy behavior or the factors contributing to it could be made available, in forms that could affect individual behavior or even social norms. (Nutritional information, for example, is readily available for packaged foods but more difficult to come by for other sources—such as restaurant meals). Second, financial incentives could be modified to encourage healthier living and to discourage unhealthy activities. For example, cigarette taxes could be increased, which would discourage smoking, especially among teenagers. In addition, an increase in the federal tax on cigarettes of 50 cents per pack would raise about $5 billion per year, according to the Joint Committee on Taxation. Third, regulatory steps could be taken to encourage healthy behavior and discourage poor health habits. For example, recent efforts have been aimed at improving the nutrition and reducing the calories of school lunches and snacks

available in schools. Some research suggests that changing the presentation of food choices can encourage healthy eating.[30]

In considering those options, it is important to recognize that there are costs to imposing regulations and levying taxes and that in many cases the benefits of specific options to promote healthy living are uncertain. For example, no consensus exists about the size of smoking's external costs, which makes determining the appropriate level of tobacco taxes difficult. Some analysts estimate that those costs are significantly lower than the taxes and settlement fees now levied. Others maintain that the external costs are greater or that the failure of people to anticipate the future effects on themselves (rather than on other people) justifies a higher tax rate on cigarettes. Technical issues complicate the debate; for example, the effects of secondhand smoke are uncertain. An argument against raising cigarette taxes is their regressivity: Such taxes take up a larger percentage of the earnings of low-income families than of middle- and upper-income families. Similarly, providing additional information about the caloric content of restaurant meals could be expensive, and it is not clear how much that information would change people's behavior or whether the benefits of those changes would exceed the costs of producing them.

More broadly, information about the benefits of eating right, exercising, and not smoking is widely available, and bringing about changes in people's behavior represents a substantial challenge. The growing field of behavioral economics is beginning to examine how the combination of information, incentives, and regulations—as well as people's inertia and biases—affects their behavior. That research may ultimately help inform efforts to make various policy changes to promote health. As the nation struggles to address the cost, quality, and access to its health care system, developments and policy changes outside the system itself will continue to exert an important influence on Americans' health, which in turn will affect the system.

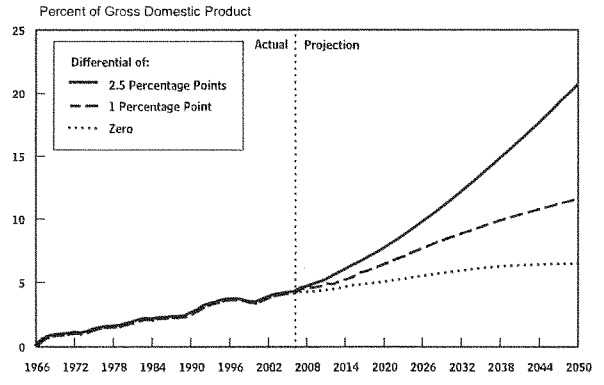
30. See Brian Wansink, *Mindless Eating: Why We Eat More Than We Think* (New York: Bantam Dell, 2006).

Congressional Budget Office

Health Care and the Budget: Issues and Challenges for Reform

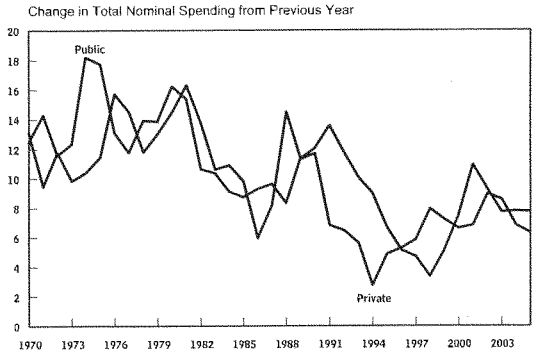
June 21, 2007

Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential



1

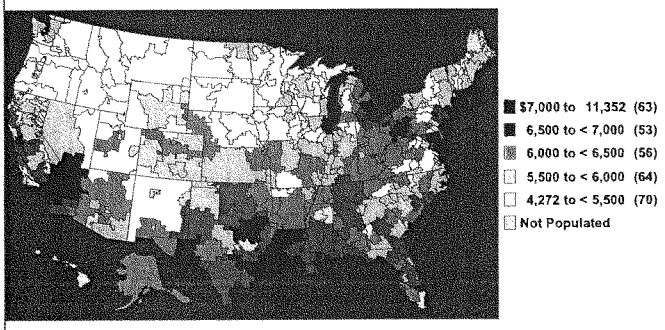
Annual Growth Rates of Private and Public Health Care Spending



Source: CMS's data on national health expenditures.

2

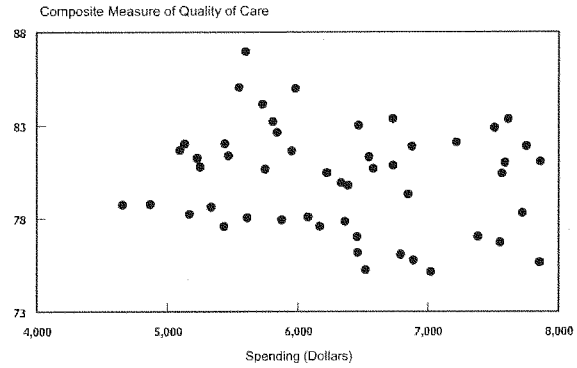
Medicare Spending per Capita in the United States, by Hospital Referral Region, 2003



Source: www.dartmouthatlas.org.

3

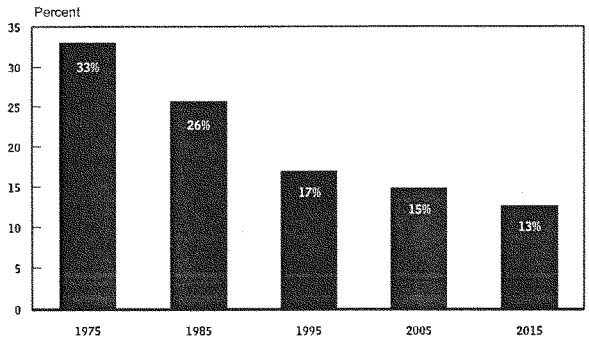
The Relationship Between Quality and Medicare Spending, by State, 2004



Source: Data from AHRQ and CMS.

4

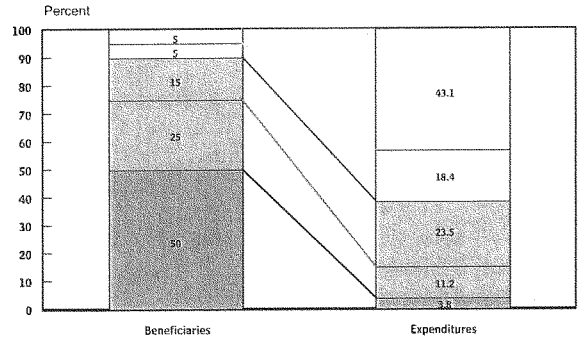
Share of Personal Health Care Expenditures Paid Out of Pocket



Source: CMS's data on national health expenditures.

5

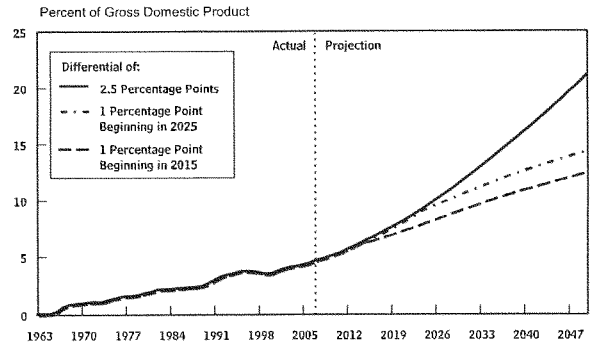
Concentration of Total Annual Medicare Expenditures Among Beneficiaries, 2001



Source: CBO based on data from CMS.

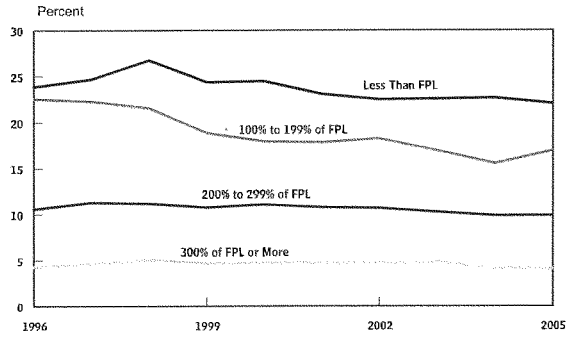
7

Effects of Slowing the Growth of Spending for Medicare and Medicaid



6

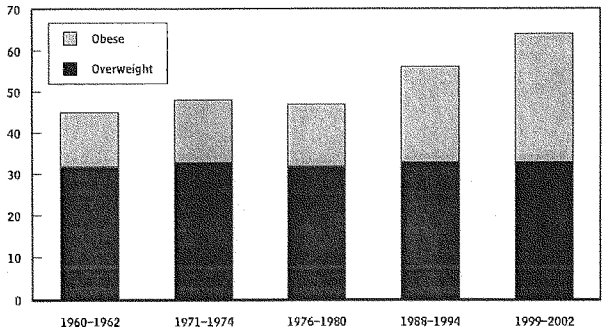
Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level



Source: CBO based on data from the Current Population Survey for 1996 to 2005.

8

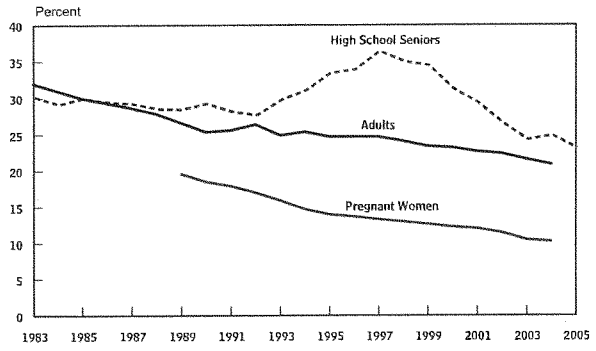
Percentage of Individuals Ages 20 to 74 Who Are Overweight or Obese



Source: Data from CDC's National Center for Health Statistics.

9

Cigarette Smoking by Various Groups



Source: Data from CDC's National Center for Health Statistics.

10

Chairman CONRAD. Why don't we go to questions because we got have members here who are very interested in pursuing their questions.

Let me ask you this question, 30 percent, I just did sort of a back of the envelope calculation. You had indicated in your testimony we could save 30 percent of health care costs if we just had best practices replicated throughout the country.

Mr. ORSZAG. Let me just really quickly note, that is a Dartmouth estimate. It is not a CBO estimate. But it is an outside estimate that it exists.

Chairman CONRAD. It is a pretty credible estimate, given the people at Dartmouth who did the analysis. I have met with them.

Mr. ORSZAG. They are credible researchers.

Chairman CONRAD. They are credible. They are serious people.

Thirty percent, we have to be spending over $2 trillion a year on health care.

Mr. ORSZAG. That is correct.

Chairman CONRAD. So 30 percent savings would be in the range of $600 billion a year. If we were able to have the practices that are already pursued in very large parts of the country. I mean geographically speaking, as I looked at your map, roughly half of the country has the practices in place that would lead to that kind of savings if they were broadly distributed.

Mr. ORSZAG. A significant part of the country. There is a question about how you do—a lot of those States are smaller States so there is a question about the population weighting. But the point holds, which is that there are significant parts of the country—in fact, the four of you right there represent parts of it—where costs are much lower than in other parts of the country and where quality is not any worse.

Chairman CONRAD. Have you thought through how we could spread those practices? How could we effectively get those practices adopted in other parts of the country?

Mr. ORSZAG. I think it will likely require two things. One is I think it does require more information about exactly what works and what does not for specific interventions, coming back to should you do an MRI after your hip fracture surgery or not kind of thing. And then it will likely also require changes in incentives for providers so that they would be presented with incentives to pursue value care, high value care, rather than just churning high cost care.

Chairman CONRAD. Let me go to another subject that has captured my attention and that is roughly 5 percent of Medicare beneficiaries, 5 or 6 percent, use half of the money.

Mr. ORSZAG. Yes.

Chairman CONRAD. They are the chronically ill.

Mr. ORSZAG. We have a chart that can pull up on that. I think that is figure five or six.

The top 5 percent in 2001 accounted for 43 percent of costs.

Chairman CONRAD. Five percent, and if we go to 6 percent they are at about 60 percent of the cost.

Well, there are people that have multiple serious conditions. We know their care is not well coordinated. There was a study done with some 20,000 of them in which we put a coordinator on each

one of their cases and it dramatically lowered cost. In fact, it lowered hospitalization, as I recall, more than 40 percent just to put case managers on each one of their cases. Because the left hand does not know what the right hand is doing.

Have you examined this phenomenon? And can you tell us is there potential for savings there?

Interestingly enough in the study that was done, not only did you have significant savings, you had better health care outcomes.

Mr. ORSZAG. Yes, Senator. Just looking at the data health care costs are very concentrated. It makes sense to look where the money is. And there is potential for cost reductions through better interventions for those types of beneficiaries.

I would note, though, that the data to date is somewhat frustrating in the sense that it does not suggest strong evidence of overall cost savings from things like care coordination and disease management. Medicare is currently doing a variety of pilot projects including a randomized experiment on precisely this topic. The early evidence suggests that quality may be improved but the net effect is not a cost saving. And it may well be that part of the problem is that it is very hard to do target the right interventions to the right subsets of the population that would most benefit from it.

Potentially, with improved electronic health records and improved health information technology, that targeting may occur in a better way.

In the absence of that the problem is that you are providing a service to a broad array of people. That costs money. If it does not work for a significant share you do not wind up saving money.

Chairman CONRAD. Let me just say in the study I was referencing the first thing they did is go in and get all the prescription drugs out on the table. They found out on average these people are taking 16 prescription drugs. And when they evaluated each one of them, they cut it in half. And that led to dramatically lower hospitalization.

You were talking about the early stages of studies that are being done now. We may find that over time the savings grow.

Mr. ORSZAG. If I could just add, I know that private firms are trying to move toward more sophisticated targeting and intervention. And we are actively monitoring those developments and eager for empirical evidence on what might work and what might not. Because again there is opportunity there. The only question is could it be captured?

Chairman CONRAD. My time has expired.

Senator GREGG.

Senator GREGG. Thank you.

I think it is important to note that it is a nationalized system which has created this inefficiency, essentially, in Medicare. Medicare is your classic universal coverage nationalized system.

And that if you are going to generate any significant savings in health care you have to get, as you said in your second set of presentation, more participation by the consumer through cost and more knowledge and transparency from the purchasers, specifically the insurer and the businesses that are paying the health care costs. If you cannot get those two things in the process, you are not going to be able to drive better practices.

It is very difficult to capture this represented 30 percent cost that is over—which is not producing better outcomes; unless you have a system which encourages the patient to be an intelligent purchaser and the insurer and the businesses that are paying for the patient when you have disconnected that cost to be informed purchasers.

In order to accomplish that, I have introduced a bill with Senator Clinton called the Medicare Quality Enhancement Act. Are you familiar with that at all?

Mr. ORSZAG. I am.

Senator GREGG. The purpose of that is to get the information into a centralized place, the Medicare information and the other major provider group information such as Kaiser Permanente statistics so that an employer or an insurer can go to a central place and get information that is hospital specific, doctor group specific on what the outcomes are and what the costs.

Do you think that that would potentially help in some of this process?

Mr. ORSZAG. Let me say this, I think the largest return to health information technology and electronic health records is likely not to be the internal efficiency gains that some studies have identified but that we have some questions about, but rather that it would provide the information to allow the kinds of things that you are talking about, comparative effectiveness research, feeding information back down to providers.

So it is sort of a systemic question. Just by itself, without those other kinds of analyses, it does not do as much as some studies have suggested.

Senator GREGG. The purpose of this is to simply create a clearinghouse where people could get that information if the information was being effectively developed by Medicare rather than having it sit in the Medicare office somewhere and having it just accessed by a small cadre of health experts who would have access to it.

I do not see it as the solution but I see it as part of the solution, one element. It is a multipronged issue.

I am wondering also, that 5 percent who is using 40 percent, that is a public policy dilemma of considerable proportions because a large percentage of that 5 percent is in long-term care and end-of-life situations; isn't that correct?

Mr. ORSZAG. Something like a quarter or so of Medicare costs are rising in the last 6 months. But the point is toward the end of life there are very concentrated health care costs.

Senator GREGG. How does an elected government deal with that issue?

Mr. ORSZAG. Again, I come back to the same thing, which is for someone who is near the end of life and there are various different interventions that are possible, if it turns out that the more expensive intervention is not actually going to extend your life anymore, you may think twice about doing it and the providers might think twice about doing it. I think, even in end of life decisions, more information about what works and what does not to extend life would be very beneficial. We do not do enough of that.

Senator GREGG. Most of those interventions that is not—there is always an assumption that they are going to make the quality of life better for the person.

Mr. ORSZAG. An assumption without evidence, in many cases.

Senator GREGG. I guess my question to you is do you have any concept as to how a government that functions on the basis of concern for the individual is going to deal with dealing with end-of-life decisions that are driving health care costs which probably do not extend life but may give you quality of life improvements?

Mr. ORSZAG. At some point, obviously, you reach value judgments that policymakers like yourself are elected to evaluate. And I will leave it at that.

I would note two other things, though. The first is that while obviously end-of-life costs are important, there is a significant amount of health care costs that are occurring outside of that.

Senator GREGG. We all accept that and hopefully we can get to that issue also.

I believe my time is up but thank you. Your information is—I totally agree with the information you put forward and just hope that we can get some action on it.

Chairman CONRAD. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. And thank you for your superb leadership on the topic and our many questions.

Senator Gregg, you say that we know what needs to be done and yet it is not getting done. I have joined with Senator Bennett, a member of the Senate Republican leadership, on the first bipartisan health care overhaul in 15 years.

So my message, Senator Gregg, is there is bipartisanship coming to a committee near you very quickly. Senator Bennett and I will be the leadoff witnesses on Tuesday for our legislation on the Healthy Americans Act, which does make it possible for all Americans, according to Lewin & Associates, sort of the gold standard of health policy analysis, to receive coverage like Members of Congress do, for the amount of money that is being spent today. According to Lewin, there would be savings of $1.5 trillion over the next 10 years.

But since we are going to be taking that up on Tuesday, let me get into my questions for Dr. Orszag.

Dr. Orszag, thank you again for a good piece of work. I want to start with one of the more important policy issues that I think is going to relate to the future of American health care, and that is how we promote prevention and wellness and, in effect, get away from this sick care system. I think this is going to be a great challenge for all of us.

Essentially what we have is a situation where the private sector, companies like Safeway, that helped me extensively with my legislation, feel that they are producing very substantial savings by rewarding prevention. And you all in Government, I think, look at these studies and are saying how in the world do we score all of it?

In fact, under our legislation we try to be very conservative, that is what the Lewin people said, and we did not score prevention at all. So we give authority to for Medicare, for example, to reward in Part B the outpatient program, authority to reward people for

lowering their blood pressure, lowering cholesterol. We do not score that. We do not score any of the private savings, for example, that the private sector is doing in prevention.

What are your thoughts on how we come up with a way to make sure that the future of American health care is built around these sensible preventive practices so we can reduce the chronic care costs Senator Conrad correctly points out and move forward with a very different vision of health care?

Mr. ORSZAG. Thanks for the question, Senator.

As my written testimony emphasizes, perhaps much more important than the health care system in determining the healthiness or health outcomes for individuals is precisely prevention and healthy living. And we have experience over the past two or three decades, a very significant increase from about one-half to two-thirds of the population that is either overweight or obese. Smoking rates have come down but they remain higher than where many medical professionals would like. And roughly half of preventative measures that are recommended—or half of the people do not get the recommended preventative steps.

All of that combined is a significant issue often outside of the health care system per se that will have substantial implications for the environment in which Medicare, Medicaid, and the rest of the system operate.

The reason I wanted to include that section of the testimony is I think this is critically important and there are a whole variety of interventions that have pros and cons and that need to be evaluated carefully but that hold the potential to improve how we live basically. And I think there are a lot of decisions. I will give you just a little vignette for a second, in which we are not behaving in a way that we even ourselves would want to.

Just very briefly, there was an experiment done, I referenced it in a footnote in the testimony, in which people were put in front of a movie and they were given buckets of stale popcorn that was three or 4 days old, nothing anyone would want to eat. The people who were given larger buckets of stale popcorn ate more of it than the people who were given smaller buckets of stale popcorn. There is a lot that we are doing that is affected by our environment and by how we make decisions that affect our health.

Senator WYDEN. I will not take on the movie theaters for purposes of——

Mr. ORSZAG. This was an experiment.

Senator WYDEN [continuing]. Of today. I just want make it clear, I want to work with you on this point because we have a disconnect. The private sector says that they are making significant savings with preventive practices. Government has been taking an approach that I think probably we would all say is more cautious. I would like to work with you on that area.

Let me ask about one other issue, and that is the role of the States. The States are very concerned about Federal inaction on this subject. What is so important about your testimony is you have made it clear that the consequences of inaction on health care are devastating. They are staggering. And I appreciate your spelling it out.

But is it not correct that the States cannot fix the health care challenge in this country because they cannot touch the tax code, which drives conduct for 170 million people with employer-based coverage. And they cannot touch Medicare, which Chairman Conrad has correctly pointed out is the driver of entitlements.

So I want to give the States a lot of credit for their good work, and they are doing imaginative, creative stuff. But is it not correct that the States cannot fix health care because they cannot deal with the biggest drivers that I mentioned?

Mr. ORSZAG. I would agree with you that with regard to cost and quality, which are two of the three important dimensions along which to evaluate health changes, the States are limited in their ability. They seem to be doing more on coverage, which is the third component of thinking about changes to the health system.

Senator WYDEN. I commend you for your good work and, Mr. Chairman, look forward to Tuesday, as well.

Chairman CONRAD. Thank you. I look forward to Tuesday, as well. You know, the ranking member threw down a challenge to let us move this to action. I could not agree with him more.

We are going to be talking about action on Tuesday and it is a bipartisan proposal. Senator Bennett, Senator Wyden, there will be others who have competing proposals. We are going to hear from them all because we think it is critical that we give the American people a chance to hear what the ideas are for really transforming the health care system in the country.

We are headed for a cliff here. I do not know what could be more clear. The only way that I see that it is going to be dealt with is in a bipartisan way. Nothing can pass here unless it has support on both sides of the aisle. And nothing can ultimately be implemented unless the president of the United States is on board.

So if we are serious here, and I think the vast majority of our colleagues are, the only way it is going to happen is with some larger agreement. That means compromise on both sides and that is always difficult.

Senator Stabenow is next. Senator Stabenow, I want to again commend for her involvement in this issue. She has been ferocious at defending Medicare and also very constructive on this Committee in the various reserve funds that have been created that really would save substantial sums of money, according to all outside experts, if they were adopted.

Senator Stabenow.

Senator STABENOW. Thank you, Mr. Chairman, very much for your focus on this and the passion of Senator Wyden in focusing, as you are, working in a bipartisan way. And Senator Whitehouse, who has brought such wonderful new passion and interest in health IT as well as other areas. I am so glad we are talking about this.

Just to stress the point in terms of why this is so critical. I believe that fundamentally it is the most important thing we can do to help our businesses be competitive in a global economy, to focus on our quality of life, on the Federal budget. It is singly the most important thing that we could do with the broadest impact for the future.

Just as an example, yesterday big headlines in the Wall Street Journal. Toyota will no longer be making automobiles in the United States. When they make them in Japan, they pay the equivalent of $95 per vehicle, as opposed to here at $1,500 per vehicle.

Chairman CONRAD. Just for the health care component.

Senator STABENOW. Just for health care. So when you couple that with the fact that, and I will not labor the point, but Japan is manipulating the yen. So they get a great discount by shipping them from Japan. So that is more American jobs gone. And our folks are here trying to figure that out.

So it is huge. And I want though to, and this is less of a question, I guess. I do have questions, many, many questions. But I would like to take us though to 30,000 feet on this for just a moment and, first of all, say prevention, obviously critical for the future, a focus on chronic diseases, diabetes, heart disease, the five chronic diseases which take up so much of the health care system. Quality, transparency, consumer choice, all of those things are critical. All of those things.

But when we only focus on that, I mean, Mr. Chairman, I believe there is a fundamental question that separates us from other countries and the reason our costs are so high. That we start from a position that is fundamentally different. In every other country that you mentioned, and I have your chart, every other country, the focus and the structure is on health care as an essential public service.

In the United States we have a health care industry. When I look at Ireland, Finland, Luxembourg, United Kingdom, Japan, Italy, Austria, Netherlands, Cuba—which is in a current film—I do not think they have more information than we do about—they have better outcomes. They do not have more transparency. They do not have more information. They do not have more efforts than we do, like we are talking about now. Why are these costs fundamentally so different with other countries that are not smarter than we are? They are not doing better quality control than we are. What is it?

My concern is that if we only focus on providers of health care, which I believe we absolutely need to be certainly—or consumers, and we do not focus on the fact that we have huge money being made off this system. That is the difference between these countries, and I realize that I come from, I think, a little different perspective certainly than many here in the Congress. But the big difference that we do not talk about is we have a round peg in a square hole and we are putting them together here as we look at how do we structure this.

And I will give you an example: Medicare has a 2 percent administrative cost. Now rather than expanding Medicare with prescription drugs within Medicare to get the savings from that administrative cost, we created a private sector model. Now we can debate good or bad. But the truth is it added costs. It did not take away costs. It added costs. It added layers of cost because private sector is 15 to 20 percent.

Medicare Advantage, and I support having a private sector option. But that was supposed to save us money. Mr. Chairman, you have been extremely articulate in that. It was supposed to save us

money. And now we are seeing that, as you indicated, even if we were to pay 50 percent more, a 150 percent for the private plans versus the public plans, we would save money if we capped it.

So I am very concerned that as we hone in on things, all of which I am very supportive of, that there is like the 800-pound gorilla in the room that we are not focusing on, which is the fact that there are those who will fight change because there is huge amounts of money being made in this system. So how do we address public interest versus private interests? And I know that is a big challenge for us.

That leads me to my question. And thank you for your input. I should also say health IT, huge savings. There is huge things that we can do.

But Medicare Advantage, CBO estimated that setting the payment for Medicare Advantage at 100 percent—and I am not suggesting that we not allow a higher payment. But if you were to set it at 100 percent for local fee-for-service as recommended by MedPAC, you indicated it would save $46 billion over 10 years.

Now CBO is saying that the savings would be $160 billion over 10 years, it is an increase three-and-a-half times higher.

So I am wondering why you are assuming the much larger overpayments? And why it is getting so much larger? What is happening in that number?

Mr. ORSZAG. What is happening is that enrollment in Medicare Advantage has grown substantially, and particularly within the private fee-for-service component of Medicare Advantage. We now anticipate rapid growth over the next decade. So the base of savings is very much larger than it was last year.

Senator STABENOW. So it is more people. Basically you are saying more people——

Mr. ORSZAG. More people driving a higher level of Federal subsidy for each—right.

Senator STABENOW. Right.

Mr. Chairman you been patient with my time. I know I have gone over that, as long as the Chairman is sidelined here, I am going to ask you one more question.

Mr. ORSZAG. Go for it.

Senator STABENOW. Is it not also true that——

Chairman CONRAD. That is good.

[Laughter.]

Senator STABENOW. Is it not also true that for those overpayments that everybody else under Part B, everybody else in the public system, is having higher premiums as a result of that?

Mr. ORSZAG. Yes, it is.

Senator STABENOW. Thank you very much. Thank you, Mr. Chairman.

Chairman CONRAD. Senator Feingold.

Senator FEINGOLD. Thank you, Mr. Chairman, for holding this hearing today. I would like to thank Dr. Orszag for being here.

I am pleased that the Committee is focusing on health care reform today. I often point out that when I go to each of Wisconsin's 72 counties every year and I hold a town meeting in every one of the counties every year. Health care is almost always the No. 1

topic that I hear about. Is a very important issue to me and to everyone.

I commend Chairman Conrad for responding to the importance of this issue by launching a series of issues on health care reform, and I am pleased to be here for the first one. There are many problems in our health care system that I think are overdue in receiving proper attention and these issues converse with the problem of the uninsured. Health care costs are driven up, hospitals and clinics are overburdened and communities and families struggle all as a result of uninsurance.

We have to figure out a way to break this deadlock. That is why I have introduced a bill with another Senator on this Committee, Lindsey Graham. Last month we introduced the State-Based Health Care Reform Act which gives certain select States the funding and authority to cover the uninsured within their State.

This bill makes political sense because it encourages initiatives we have already seen in places like Massachusetts, Illinois, California and Wisconsin, among others. It does not prejudge the type of reform that a State should adopt. So many different political philosophies can be on the table.

Additionally, the proposal makes fiscal sense. Our bill provides up to $40 billion for States to use for reforms and it is entirely offset.

If passed, this would provide a path to nationwide health care reform while still maintaining budget neutrality.

Senator Graham and I are certainly from opposite ends of the political spectrum. We are from different areas of the country and we have different views on health care. But we agree that something needs to be done about health care in our country.

The only question I would ask you is that, as you know, a lot of different solutions have been proposed to the problems in our health care system and most of them have come under political attack. Much of the data generated by economists conflict on what would be the best approach.

The bill that I have introduced with Senator Graham would allow States to propose amending Federal law with a Congressional sign off in order to address the uninsured health care costs and preventions. States would have the flexibility to decide about issues of such as employer-sponsored insurance.

Do you think that there is sufficient data now to show that any one particular approach is the best way to help our country lower health care costs?

Mr. ORSZAG. What I would say is I think there are a variety of approaches that hold promise. One of the challenges that we have is that I have not seen, and I do not think one exists, a comprehensive plan that would, given the available information today, credibly bend that curve sustainably over the long-term.

So one of the challenges is we need to be trying different things, seeing what works, and then readjusting as we figure it out. And the sooner we start that, the better off we are going to wind up being.

Senator FEINGOLD. Exactly. So the answer to my question would be that there is not sufficient data or not sufficient experiments to get that data.

Mr. ORSZAG. That is correct.

Senator FEINGOLD. Do you agree that the Feingold-Graham State-based approach could be useful in gathering better data on what would be better for the country as a whole?

Mr. ORSZAG. There are a variety of approaches that are possible and I have had an opportunity to take a look at the legislation and that could be among the choices that you all embrace.

Senator FEINGOLD. Thank you very much. Thank you, Mr. Chairman.

Chairman CONRAD. Thank you, Senator Feingold. And thank you for your contributions to this Committee.

Senator Sheldon Whitehouse is a new member of this Committee but already he has proved to be somebody deeply knowledgeable on health care. He and I have had extended discussions about his own experience in his home State where he was given responsibility for getting a major State program in shape and rescued from bankruptcy.

And Senator Whitehouse, I have asked to serve on a special panel of the Budget Committee to focus on what we can do to accomplish significant health care savings, at the same time improving health care outcomes. He has made a valuable contribution in just his short period of time on this Committee.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Well, thank you, Chairman. I am moving down one because there seems to be a technical difficulty with my microphone at this seat. I am not trying to get further away from anybody or closer to anybody.

I do want to thank you for leading the Budget Committee in this direction. It is so important that we get our arms around this problem. And it is one of the most frustrating issues that we have to deal with in this Congress because, frankly, so much of the cost that we are dealing with is unnecessary. Very often we are presented with situations where it is a zero-sum game and there is a winner and a loser. And to the extent you add a dollar to the winner, you take away a dollar away from the loser.

This is not one of those situations. This is a situation which, by simply making the system run more effectively, we can have win-win-wins that improve health care, lower costs, make people happier within the system. It is a colossally challenged system right now.

Dr. Orszag, welcome. Would you agree that there are enormous systemic inefficiencies in the American health care sector?

Mr. ORSZAG. Yes.

Senator WHITEHOUSE. Would you agree that quality reform presents an opportunity for bringing down cost in ways that are helpful to patients as well as to the system, quality of care reform?

Mr. ORSZAG. I think there are opportunities to reduce costs without harming health outcomes.

Senator WHITEHOUSE. Even with improving.

Mr. ORSZAG. Difficult to capture, but yes.

Senator WHITEHOUSE. Even with improving health outcomes.

Mr. ORSZAG. And perhaps in some cases to improve.

Senator WHITEHOUSE. Would you agree that that can include improvement in the delivery of procedures, as indicated by the won-

derful Keystone Project in Senator Stabenow's home State that was reported by Johns Hopkins to have saved $160 million in just a section of Michigan's intensive care units over 15 months?

Mr. ORSZAG. Changes in procedures would be among the things that would be in the toolkit.

Senator WHITEHOUSE. And certainly Pennsylvania's recent study that shows literally billions of dollars in hospital acquired infections shows another opportunity for how improved procedures can be a part of that quality reform.

Mr. ORSZAG. There are opportunities throughout the health sector and the question is how to capture them.

Senator WHITEHOUSE. Would you agree also that, setting aside procedures, there are prevention techniques that present the possibility of saving cost for the system as demonstrated by Safeway's work with its own employee base, reducing cost by enhancing prevention?

Mr. ORSZAG. I think there is an opportunity. I would say that the evidence to date is a little bit more sketchy in terms of whether overall preventative medicine interventions help reduce costs as opposed to improve quality. Again I think again you have this targeting issue which is preventive measures may work for a subset of the population. But if you are provided that test or screening to a whole bunch of people, in some cases it may warrant additional health care costs, and in some cases it does not matter. So you have costs that are not as targeted to generate the savings.

Senator WHITEHOUSE. The fact that it is prevention does not mean that it costs savings but targeted correctly prevention can save money in the system and improve health care.

Mr. ORSZAG. There is a potential for that, yes.

Senator WHITEHOUSE. Would you agree that the reason that these things are not happening, given things like the RAND Corporation's analysis showing that it is somewhere between $81 billion and $346 billion a year for properly supported HIT enhanced quality reform is because there are market failures that are driving this?

Mr. ORSZAG. I think there are a variety of incentive distortions and problems that are creating the kind of—and information problems—that are creating the kind of variation we saw up on that chart.

Senator WHITEHOUSE. Would you agree that those market failures can be addressed or reduced through structural reforms such as reforms of the reimbursement system so that it is pointed in the direction of the care we want? Or institutional reform so that there is, for instance, a place you can go to get the best information about a particular area of care that does not exist right now?

Mr. ORSZAG. I think it is pretty clear that in health care we get what we provide incentives for. And if we develop more information and move toward a value-based system of incentives we would wind up with some combination of higher quality or lower cost.

Senator WHITEHOUSE. It strikes me that we have kind of a microcosm in this building of the health care problem, in which there are externalities that prevent the right thing from happening. Here some of the externalities include the budget restrictions of this Committee and the actuarial and other process restrictions that

bind you to certain kinds of analysis and determinations before you can score something positively.

Are there ways, say working with entities that are Government controlled but not within the Federal budget, that we could experiment more successfully without the need to be able to prove the point to the extent that a CBO score is the gateway but you can kind of take more chances without affecting either the budget rules of the Senate or the professional analysis that you are obliged to follow as a CBO scorer?

Mr. ORSZAG. What I would say, Senator, is that CBO scores are used by the Committee and the Congress as you all see fit and that, in many cases, for example because the budget window has been chosen by the Congress to be five or 10 years, a lot of things for example with regard to prevention may show up well outside that budget window.

Beyond that we are always looking for additional evidence that will inform our estimate.

I guess my response would be we have a job to do and we are going to do it and you all can use the information as you see fit. And that is not for me to comment on.

Senator WHITEHOUSE. I will followup more in my second round scared because my time has expired. I thank the Chairman.

Chairman CONRAD. I thank Senator Whitehouse.

I want to go back to Medicare Advantage because I am increasingly concerned about what I see happening. Medicare Advantage are private plans that compete with fee-for-service traditional Medicare. Medicare Advantage plans were sold to the Congress based on the notion that they would save money. The whole idea with Medicare Advantage was that it was going to save money. It was going to be less costly than traditional Medicare because the private sector was going to bring efficiencies to the table and the result would be reduced costs.

In fact, Medicare Advantage, when it was adopted, was capped at, as I recall, 95 percent of traditional fee-for-service Medicare. That was then raised, as I recall, to 97 percent. We now know on average that it is 112 percent and, in fact, in scoring done by the CBO we see if we put a cap of 150 percent of a traditional fee-for-service Medicare there would still be savings at that level.

Now we have a runaway train here. 19 percent of Medicare enrollments are now Medicare Advantage. That is up from 13 percent in 2004.

What do you see as the implications for the cost of Medicare and the future of Medicare if these trends continue?

Mr. ORSZAG. Senator, if over the next couple of years the rate of growth that we have experienced recently in Medicare Advantage were to continue, I think the result would be a fundamental change in the nature of the Medicare system that may then be hard to reverse, including within it higher costs than are currently projected. So the more rapid the growth in Medicare Advantage under current law the more fundamental the change in the nature of the Medicare system and the higher the cost of that system.

Chairman CONRAD. That is sobering testimony. You know, I see people advocating even more costly health care systems for the country. I personally do not believe that is the answer. We are now

spending one in every six dollars in this economy for health care, one in every six dollars. No one else in the world is spending more than one in every nine dollars in their economy in health care. And we are not getting better health care outcomes.

What I have just heard you say is that if the current trends on Medicare Advantage continue those costs will only escalate and, in fact, it may become even more of a challenge to get all of this under control. Am I hearing you correctly?

Mr. ORSZAG. Yes you are, Senator.

Chairman CONRAD. Let me ask you, you are somebody who has studied this carefully and closely. You have one of the best groups anywhere in the country, perhaps anywhere in the world, organized to evaluate and understand these issues. I heard your answer to Senator Feingold, I think it was Senator Feingold, earlier that you do not see a comprehensive plan that is out there that, if adopted, we could be confident would get this under control. Was I hearing you right?

Mr. ORSZAG. Basically yes. There are things that seem promising and that hold out the promise of bending that curve over the long-term. But in terms of having the confidence to say in 2025 there would be a reduction of X percent in health care expenditures from known interventions that unfortunately is not where the state of knowledge is.

Chairman CONRAD. My colleague, Senator Gregg, was suggesting the President had put on the table a plan that would save substantial money for Medicare, billions and billions of dollars was his assertion. Have you evaluated the President's proposal?

Mr. ORSZAG. Yes, we did. In the analysis of the President's budget that we did earlier this year we included a box on the longer-term consequences from those changes in the Medicare, in particular. What we suggested is that if they were sustained over the next—through 2050, they would indeed succeed in reducing Medicare outlays substantially in that year by over 20 percent.

However, there is a very significant question, as I noted in my testimony, about the sustainability of changes to Medicare or Medicaid over that long period of time without broader health care cost growth slowdowns. So I think one would imagine that if the kind of payment update reductions that were carried out under that policy were followed through with over a 45 or 50 year period, significant excess problems would be created in the Medicare program unless the overall rate of health care cost growth slowed.

Chairman CONRAD. Let us rivet that point. Why didn't Congress rush to embrace the President's proposals? Because other objective experts told us that if we did embrace them that access to health care by senior citizens would be threatened and endangered. That is why we did not rush to embrace the President's proposal.

Look, I have voted for—I have voted for saying to those among us who have the greatest wealth that we ought to pay more. I have embraced the proposal. I think that has to be adopted. I think it makes no sense to me, there is nothing progressive about having a working family in effect subsidize wealthy retirees. I have never understood why that is a progressive value. And I have voted for, in another Committee in which I participate, the Finance Committee, to, in fact, means-test Medicare. And I will vote to do that

again. Because I think it is one part—it comes nowhere close to solving our problem—but it is one contribution that can be made in an overall effort.

My time has expired, so we will go to Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Just one point procedurally, Dr. Orszag. There has not been any formal effort to look at the various proposals before the Congress, is that not correct?

Mr. ORSZAG. It depends which proposals you mean, sir.

Senator WYDEN. My understanding is you all are getting a private group together to advise you. And at some point when proposals are submitted then there will be an effort to look at a formal examination of costs and scoring and the like. I know we have—I have used Lewin & Associates because they are former, I guess, graduates of CBO. And we think our cost analysis that was done by them of the amount that is spent today being sufficient to cover people and the $1.5 trillion savings over 10 years, we think that that is authoritative.

But I just want to be clear on the record, because we have now gotten to the point of discussing proposals, you have not done formal scoring of the kinds of proposals that are being considered today; isn't that correct?

Mr. ORSZAG. We have not been asked to and we have not done a cost estimate of your proposal, for example.

Senator WYDEN. And we look forward to sitting down with you for a formal effort to have an examination. I appreciate your making the record clear on that point.

Two other areas. One is administrative savings in American health care. One of the areas that we believe Lewin has found significant administrative savings is just using electronic transfers, the sign-up process and the paying of bills. For example, in our State there is something like 33 categories of Medicaid. And everybody spends all of their time trying to dive into the various Medicaid boxes in order to get covered.

What we have found through the Lewin analysis is that once people enter the system and everything is handled through electronic transfers there are substantial savings in the administrative costs and the Lewin people scored that in our proposal.

Do you generally, and again I do not want to get you pinned down about formal increase versus informal inquiries. But generally, the proposition of using something like that as a way to reduce costs so that poor people do not go through this degrading god-awful process that is both inefficient and inequitable is something that ought to be looked at for the future?

Mr. ORSZAG. I agree it should be looked at carefully.

I would note that since there have been several references, we have actually invited the authors of the RAND study on health information technology in to CBO to present their results. And I would be happy to provide our analysis of that study at anyone's request. In fact, we are planning to do a study on the returns to health information technology.

Senator WYDEN. I think that is a fair point. The reality is that the colleagues here have good ideas, Senator Stabenow, Senator Whitehouse on technology, Senator Feingold. I am very sympa-

thetic to a broad role for the States. So we appreciate your making it clear you want to work with all of us.

Let me go now to the ramifications for people who have coverage with respect to the status quo.

Families USA did an analysis indicating that if you have coverage today, in their judgment, you essentially have $1,000 of your premium go to pick up the costs of the uninsured. This stems from the fact that uninsured folks go to hospital emergency rooms and all of that gets pushed off on other parts of the system.

Without saying whether it is $1,000 or $800 or what have you, can you give us your assessment of what the present system means for people who have insurance today, the auto worker who has insurance today, what it means generally for them given the fact that so many are uninsured and there is a Federal law that entitles them to coverage in emergency rooms?

Mr. ORSZAG. I would say three things. First, I think the things that we were talking about before in terms of higher utilization than in many cases may be necessary drives up the cost for the people who have employer-sponsored insurance. The care that is provided to the uninsured, even though it is lower cost than for the insured, still winds up driving up the costs for the insured because of the different pool. And that is the effect that you noted.

But I would also note that adding people, moving people from the uninsured pool to the insured pool, can have a variety of changes with complicated impacts on overall costs.

Senator WYDEN. Let me see if I can get one other question in. What is your assessment of the situation today with private insurance, where there is so much cherry picking going on? And private insurance companies, many of them, not all, essentially try to find healthy people and send sick folks over to Government programs more fragile than they are? What are the ramifications, as you look at costs, of this cherry picking situation?

Mr. ORSZAG. Well, there are significant incentives for insurance firms to try to select particular types of beneficiaries and that does, as you know, occur. That can drive up the cost, both in terms of administrative costs and other costs in the system.

One of the issues involved in reform of the health care system is whether it remains employer-based or not. And if not, what kinds of pooling mechanisms would exist outside of the employer in order to avoid some of the problems that occur in the individual insurance market where some of the selection effects are most severe.

Senator WYDEN. With the Chair's indulgence, I know colleagues are waiting as well, I have asked every economist, and you have some of the best economic stripes in the country, whether they agree that under the tax code today, essentially the tax treatment of American health care disproportionately favors the most affluent and promotes inefficiency at the same time. Every previous economist, liberal, moderate, or conservative has said yes. They think that is what happens with the current tax code.

Just because we have you here, do you share that view as well?

Mr. ORSZAG. Yes.

Senator WYDEN. Very good.

Mr. ORSZAG. Let me just add really quickly that I think, in general, there are a whole series of incentives that we provide through the tax code to promote health, retirement, home ownership, et cetera. There are questions that exist about the efficiency with which a lot of those are done because they are often provided in the form of a deduction, which ties the size of the incentive to one's marginal tax bracket. And that may or may not be the optimal thing to do.

Senator WYDEN. After 60 years of wrangling on this issue, I think we are right on the cusp of bringing both political parties together for a fix. And if we are going to get there, it is because we are going to have your good work and your good offices in the effort to get it right. And I very much look forward to working with you in the days ahead.

Thank you, Mr. Chairman, and again for your leadership, Mary Naylor's leadership, putting all of this Committee time into what is clearly the premier domestic issue of our time and look forward to working with you and all of our colleagues on it.

Chairman CONRAD. We thank you for your leadership and involvement, as well.

Senator STABENOW.

Senator STABENOW. Thank you, Mr. Chairman.

I also want to thank Senator Wyden again for working in such diligent way.

I did want to just go back to one of your responses to Senator Wyden, when you said that the uninsured would have lower cost health care.

Actually, I would contend, and we have seen numbers, that they actually received higher cost health care because they are more likely to be using an emergency room. What we see, certainly in our State where there are a number—we have a large number of people who have private health insurance. And we have been able to track with local emergency rooms what happens not only with the uninsured but when co-pays get so high that people choose not to go to a doctor but wait and go to an emergency room. The emergency room costs are a much more expensive way to cover things that could otherwise be done through a physician's office.

So I am not clear on would you agree with that? Emergency room care is certainly a much more expensive way to treat the uninsured.

Mr. ORSZAG. Senator, my written testimony on pages 16 and 17 covers this issue and has the citations for the statement that I made.

Senator STABENOW. OK. Let me move to one issue specific on cost. You indicated in your information that the rate at which health care costs are growing is the No. 1 issue, and I would agree with that. And it was beyond demographics. It is not just that we are all getting older, we baby boomers. This is about cost growth in what is happening. Again, I would argue structure and policies and so on actually add to that.

One area where we know there is substantial savings, and I would like your comments on, relates to competition within the prescription drug area. We know, the latest numbers show, that the average retail price for a brand name prescription drug was

$102 in 2005 versus $30 for a generic drug. And that in every case where there is a generic and a brand, through that competition the price is lower.

In fact, INS Health has said that on average generics are anywhere between 30 and 80 percent lower. We have actually had a success in this area, I am very pleased, in the Prescription Drug User Fee Bill that just passed the Senate, a bipartisan effort that began with a bill that Senator Lott and I have on closing loopholes to allow more generic drugs on the market was able to pass. It was a significant policy and it was great, in addition to Senator Brown, to have Senators Thune, Lott, Hatch, and Coburn with us. So this was an effort to really look at cost, generic drug costs. In fact, you scored that as savings.

Mr. ORSZAG. See.

Senator STABENOW. I am wondering if you might speak more to the strategy of using generic drugs, lower-cost generic drugs, in the marketplace as it relates to overall spending on prescription drugs which, at least with the private employers I talked to, they say that is the No. 1 driver in terms of the area of cost they have the least control over, and that is going up the quickest.

Mr. ORSZAG. A few comments. The first is that there are a variety of policy measures that are coming before the Congress including follow-on biologics, for example, that will have implications for overall costs.

The second is that prescription drugs are an important but not overwhelming share of overall health care spending, something like a tenth. So one needs to put it in perspective.

The final thing is actually over the past few years one of the things that has slowed overall health care cost growth relative to where it would otherwise be as that prescription drug spending has not been growing as rapidly as it did a few years before that.

Senator STABENOW. Thank you, Mr. Chairman.

Chairman CONRAD. I thank the gentle lady from Michigan.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

To pick up where we left off—and by the way, I think you are spectacular. I think your office is spectacular. I do not mean any of this critically but I do think we have kind of a potential logjam coming up.

You said that there are things that you cannot score yet for savings because there is insufficient experiment or insufficient evidence to give you the basis of knowledge on which to make that calculation and to prove out the savings.

If in return, or in the next step, there is insufficient experiment because we do not fund it and there is not adequate, what I would call R&D being done on health care reform in America, and if in turn we do not fund it because you cannot score it——

Mr. ORSZAG. Then we are sort of stuck.

Senator WHITEHOUSE. We are sort of stuck.

So the question is are there ways, by moving some of this into for instance an NGO or a federally chartered but not federally budgeted entity, that we could take what we know to be the sensible moral judgment to move forward on this without having it im-

pact the budget scoring that is so necessary to the workings of this Committee?

Mr. ORSZAG. Senator, for example on comparative effectiveness research, so looking at what types of interventions and technologies work and which do not, there are a variety of approaches out there, some of which are sort of quasi-governmental, the National Academy of Sciences/Institute of Medicine or something like that, that have been proposed. And there are various different financing mechanisms that could be associated with that. We are going to be laying all that out.

Senator WHITEHOUSE. I do not mean to suggest that there is nothing going on. My concern is that given the scope of the problem that you have elucidated and given the dollars involved, which are—I mean, we are trillions of dollars into health care and it is climbing rapidly—do you believe at this point that there is enough work being done on the sort of extermination and evidence aspect, the R&D of health care reform in America?

Mr. ORSZAG. No.

Senator WHITEHOUSE. So to notch it up a bit would be my issue. We can work further on that.

Mr. ORSZAG. All I can do is, for example, within CBO we are taking a variety of steps because I think out of necessity we are increasingly becoming the Congressional health office and we need to.

Senator WHITEHOUSE. With good reason.

Mr. ORSZAG. We are shifting staffers into that area. We created a panel of health advisers. I created a new health intern program. We are moving in that direction and I think broader changes are warranted, also.

Senator WHITEHOUSE. Let me make an observation and you can tell me if this is beyond your expertise. It strikes me that one of the big problems in health care is the cost shifting problem, that everyone has their own parochial part of the system. And if they can push costs out of their part to other places, they become winners, although they create costs overall.

The perfect example of that is massive claims denial by insurers which moves dollars out of their portfolio but at the same time requires providers around the country, doctor's offices, to staff up with an army of people to fight back against the claims denial and the costs of that whole battle over claims denial and approval continues to swell, continues to burden the system in a kind of an arms race with no health care value. And yet, once you are locked into that dynamic, you are kind of stuck with it.

It strikes me that if you look at the insurance model in this country, it is characterized by three things. One, the desire to not provide coverage to people who might get sick or who you can find out are sick already. Two, the desire if you get somebody into your portfolio who becomes sick to try to find a way to deny them coverage. And three, if you are stuck and actually have to deny them coverage to try to figure out a way to deny as many of their claims as possible.

I do not attribute that to evil intent on the part of the insurance industry. I think institutions respond to economic signals. And I would be interested in pursuing with you the extent to which you

think the insurance business model and its cost shifting dynamic relates to specific attributes of our health care system that encourage and incent that kind of behavior and how we might reverse the polarities of the incentives the health care system turns out so that the productive insurance model, the productive business model for the insurance industry becomes how am I your ally? How can I be helpful to you navigating this complex system? How can I warn you when you need certain tests and things based on your age and your family's health history? How can I be there for you when you have a call in the middle of the night and you do not know you really want to go to the emergency room?

I think until that changes, we have a huge problem with the insurance industry. And yet they could provide such a valuable function. Are you looking in any way at how the signals the system sends out incents the business model of the insurance industry that creates so much cost-shifting?

Mr. ORSZAG. What I would say more broadly is precisely because it is so hard to get at specific steps that would slow overall health care cost growth, for many participants in the health system it is in the short term more financially advantageous to shift costs across different sectors than to get at that underlying rate of growth because that challenge, which is the fundamental one, is so hard to grapple with.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Chairman CONRAD. Thank you, Senator Whitehouse.

We have talked today about cost growth in the whole health care sector as being the biggest contributor to the long-term challenge. We know we have a secondary issue which is also serious which is this demographic time bomb.

What are your assessments of the contributors to this cost growth? And have you been able to put them in some kind of priority order? That is, as you analyze the system what do you see as the major contributors to this cost explosion in health care that is far above the underlying rate of inflation in the economy? And what is your assessment of what could be done about each of those areas?

Mr. ORSZAG. The first thing I would say is that this is another topic on which CBO will be issuing a study over the course of the year, so we are focused on that. My written testimony covers some of the things.

One of the big drivers is the increased capabilities of medical technology and the average return to the advances in technology has been high. So if you look at the health care that we have today it is better in terms of delivering care, improving health than 50, 60, 70, 80, 100 years ago.

But the improved technologies are often also applied outside of the range in which they actually help to improve health. And so you have this thing——

Chairman CONRAD. So it is overutilization.

Mr. ORSZAG [continuing]. Where something is introduced and it can produce an average benefit. But it is then expanded beyond, expanded into areas where again if we had the evidence it may not be warranted.

So I think the key question is how to continue to encourage that kind of innovation which is beneficial while driving it toward the higher value applications that generate the best outcomes.

Chairman CONRAD. What other contributors to cost growth do you see?

Mr. ORSZAG. There are various different ways of parsing that. One is the increased prevalence of chronic conditions, including the ones associated with obesity. So for example, the share of Medicare costs that are attributable to obese beneficiaries increased from 9 percent in 1987 to 25 percent in 2002. If continued increases in obesity are carried out in the future and then start to affect the pool of Medicare beneficiaries that share may well go up even further.

That increase is disproportionate to the increase in obese beneficiaries, in part because obese beneficiaries cost a lot more that—roughly a third or so more than beneficiaries of normal weight.

Chairman CONRAD. What can be done to address a dynamic like that one?

Mr. ORSZAG. That is very hard. I gave the, I guess, trivial example of mindless eating. But I think there are a whole variety of interventions——

Chairman CONRAD. That was your stale popcorn.

Mr. ORSZAG. That was the stale popcorn. By the way, that was an experiment. And someone walked out of the experiment afterwards. And they were given free popcorn because it was an experiment. And they complained that the popcorn was stale, I want my money back. But in any case——

Chairman CONRAD. That was not a Member of Congress.

Mr. ORSZAG. No.

There are a whole variety of things that we talk about in the testimony having to do with better information, having to do with incentives, and having to do with other interventions. So for example, and this is not to embrace this kind of change but just the sorts of things that researchers are starting to identify as affecting what we eat and how we exercise, putting fruit and vegetables toward the beginning of a cafeteria line rather than at the end seems to significantly boost consumption of fruits and vegetables, as opposed to the high calorie, low nutrient alternative foods that are then placed at the end of a cafeteria line.

How you engineer that or how you adopt changes like that and the pros and cons of different kinds of things are important challenges that we have not yet fully tackled. So we do not really know the answer but certainly more information and changes in incentives and changes in the environment in which we are making decisions could potentially have an effect.

Chairman CONRAD. The incentives in the system almost everybody has talked about we have the incentives wrong because what we incentivize are procedures because that is what we pay for. We pay for procedures. You pay for procedures, you get a lot of procedures.

We do not incentivize keeping patients well. With that said, I have never been certain how you would construct a system that would provide incentives for keeping patients well. Have you

thought about how you would structure a system that would do that?

Mr. ORSZAG. Yes, there are different approaches that have been discussed along that dimension. Some of them are processed based. So the things that we know, you develop evidence that, for example, having a nurse practitioner coordinate care, if the evidence existed that that improved health outcomes, you could then pay for that sort of approach. That is one way of structuring finances, financial incentives.

Another way is to look at outcome-based things. You basically provide incentives if you achieve better life expectancy for your beneficiaries or lower blood pressure or other things that you can measure in terms of outcomes.

There are whole variety of things that are starting to come together in terms of metrics that can be used but it is early in terms of how one would fully design a value driven set of incentives.

Chairman CONRAD. You know, the ranking member challenged us in the early going here to take action, and sign me up. I am eager to take action. The thing is I do not want to take action that proves to be unsustainable. I do not want to take action that threatens people's access. I fear very much the President's proposal, based on other's testimony, would do that.

So we have to go through a process here, and that is what these hearings are about, of identifying options and then on a bipartisan basis trying to find a way to embrace them. That is not easy to do here. Even if you have a majority of members of the Senate that are for something, we all know a majority is not enough. Because if you do not have a super majority you cannot end the endless discussion that will occur here and the filibustering by amendment that can occur here. That means you have to have at least 60 votes in the Senate.

And then, of course, you have to deal with the House of Representatives, you had to deal with the White House. The only way that I see this proceeds is if there is a group that is given responsibility to come up with a plan that is totally bipartisan in nature, that involves all three of the entities that have to be brought together for any plan to be actually implemented. That means the House of Representatives, the Senate, the White House, all of them have to play a role not only on the landing but on the takeoff. If people are not involved—one thing I have learned around here, if people are not involved in the development of the plan, they are not going to support the plan when the going gets tough.

But that still leaves us with the question of a plan. And a plan that could really make a meaningful difference and one in which we could have confidence that it would not only save money, but at least do no harm to health care outcomes and hopefully improve health care outcomes.

I just want to go back over what I heard you say. What I heard you say is you are not aware of any comprehensive plan that exists at this moment that we could be assured would save money and at least not hurt health care outcomes. Did I hear you correctly?

Mr. ORSZAG. That is correct. I do think that there are steps that can be taken to move toward creating the opportunity for such ap-

proaches or options to exist and that regardless of your broader vision for health care reform would make sense.

Chairman CONRAD. Tell me what some of those would be. What are the things, because you said earlier you see promising signs on the horizon. Let me just give you the time to go forward and tell us what are the things out there that you see as promising that ought to be pursued?

Mr. ORSZAG. Let me mention three. The first is that one could, if you as a policymaking body were committed to it, significantly increase the share of health care spending with which there is some evidence associated. So the Institute of Medicine is contemplating a goal of increasing that 25 percent share to something like 80 percent or 90 percent by a date certain.

Chairman CONRAD. Let's talk about that, the 25 percent share, what does that reference?

Mr. ORSZAG. There are very rough estimates but that if you take total health care spending and you ask do we have any evidence that this intervention works better than that intervention? Or this is better than that? Only about a quarter of health care spending is arising in that evidence-based information box.

Chairman CONRAD. Only about one-quarter of health care spending we can say, based on evidence, is actually contributing to improved outcomes?

Mr. ORSZAG. You can think about it that way. The vast majority of health care spending is occurring where we just do not know.

Chairman CONRAD. We do not know.

Mr. ORSZAG. So a sensible approach presumably, regardless of whether you favor a consumer directed health plan kind of system in which consumers need the information, a single payer in which the single payer administrative body would need the information, or some mixed system where State Governments, Medicare, Medicaid and insurance firms would need the information is you need the information.

That brings me to my second point which is I think it is unlikely that you are going to get up substantially above a quarter on that share in the absence of a broader system of electronic health records. And I think that the return to health information technology is much more likely to occur in providing and feeding information into this kind of analysis than in the type of cost savings that are contained in the study that has been discussed here at the hearing.

The largest return may well turn out to be other things like providing the data that could be then used. It is very likely that you are going to be able to get up to 50, 60, 70 percent of health care costs having some evidence associated with them relying solely on randomized control trials. And I am not even sure that you would want to, from a cost-effective basis.

So you will need to struggle with the difficulties of statistically analyzing large bodies of panel data which could be provided by electronic health records.

The final category that I would—actually I will give you four categories.

The third category has to do with disease management and chronic care and trying to evolve toward better targeting of those

interventions so that they not only improve quality where there seems to be some evidence that they do, but that they actually reduce costs. So finding the right interventions where they actually work seems——

Chairman CONRAD. I am a big believer in your No. 3. That is where the money is. When I went to business school we were taught to focus where the money is. And here are 5 or 6 percent of the patient loads using half the money.

Mr. ORSZAG. And again it can be integrated with my first point which is we again need to be looking at disease management programs from the perspective of what works and what does not.

Chairman CONRAD. What is your fourth?

Mr. ORSZAG. The fourth category was just something that Senator Wyden and others have suggested, which has to do with prevention and incentives for healthy living so that trends like the dramatic increase in obesity are addressed in some way because in the absence of that you are going to be dealing with a much larger burden for the health care system regardless of how effective you make it in processing information and being value-based.

Chairman CONRAD. All right.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

I asked you earlier whether you thought there was adequate research and development being done on the health care reform at this point, the health care reform side, how we get these savings. You said no. I want to ask you for some kind of metric on that.

How close are we to what you think would be the ideal level of experimentation and evidence generation, research and development, on how we work through these steps that you have described? Are we like the Lewis and Clark expedition, what we are doing so far, with a vast unexplored landscape in front of us? Or are we something who has like cleaned six room of the house, there may be one left to do but we have pretty much done it?

In those sort of ranges, how close are we to where we should be, in your view, in terms of investment in experimentation and analysis of how we get ahead of this problem?

Mr. ORSZAG. I think we are closer to the Lewis and Clarke trip.

Senator WHITEHOUSE. To followup on what the Chairman asked you about wellness incentives, if you are going to pay for wellness incentives through an insurance company model, and if the insurance company model exists in a very mobile population in which a particular insurer can bet that a fairly significant group of their insureds is in three or five or 7 years going to move on and become somebody else's problem and, in fact, in their old age are likely to become the United States Government's problem, what does that do to the calculation of—assuming that they are being rational economic actors in the American business model—what does that do to the return on investment calculation that they would logically make about investing in wellness incentives? And what does that mean structurally about that model in terms of its ability to provide optimal wellness incentives?

Mr. ORSZAG. It reduces the incentive to invest in—if you cannot capture the full benefits because people are churning and turning

over and leaving your plan, your incentive to invest in that kind of activity is reduced.

Senator WHITEHOUSE. And it is reduced in an inefficient way in the sense that it creates a suboptimal level of investment?

Mr. ORSZAG. From a national perspective there can be lower levels of preventative steps that are taken as a result of that incentive issue that we just discussed.

Senator WHITEHOUSE. Mr. Chairman, I would want to conclude. First of all, thank you for letting us have the third round. I appreciate it very much and I know we are going to have a vote very soon.

But I just wanted to conclude again by complementing both of you on this. I think the Chairman's direction of the Budget Committee into the health care issue is extremely wise and vitally important. And I think, Peter, your transformation of your agency into one that is far more adept and focused on the looming health care problem that we face is also very wise.

And I think that working together we have the chance to get ahead of this problem. I live constantly with the very, very deep anxiety that if we do not get ahead of this problem, if we do not work hard at it now and do the structural things will allow the system to work better and sort of cleanse itself and be efficient and send correct price signals and began to become a system we can be proud of rather than one that screams distress from really every quadrant, we are then going to be left with really harsh choices because we have not left ourselves the time to work through some of these problems.

And those really harsh choices are ones that I hope we never have to face. And if we do have to face them because we did not do the work in advance, then really shame on us. Because the people that will suffer are people who are in a lot of distress already.

So I think we have a very, very high moral obligation to pursue this very aggressively. And I appreciate so much that this Committee has been turned in this direction by the Chairman and that your organization has been turned in this direction by you.

Chairman CONRAD. I thank Senator Whitehouse and again, I thank you for the energy and attention you have brought to this subject.

Director Orszag, we are all delighted at the leadership that you have brought to CBO. It is really exceptional and we appreciate very much the thoughtfulness that you direct to these issues.

This really is the challenge of our time in terms of the fiscal future of the country. I am not talking about just the human element of all of this because health care touches every one of our lives. We have simply got to do a better job of facing up to what is the preeminent fiscal challenge that this country faces.

I am delighted that you are in this position of responsibility, Director Orszag, because I think you have the ability to help us work our way through this.

I also want to acknowledge the work of Senator Gregg, who is committed to addressing not only this long-term entitlement issue but the others as well. I am eager to work with him because nothing is going to happen unless we work productively together. That is the reality of this place and of this time.

I thank you and thank the members of the Committee for their participation this morning.

[Whereupon, at 11:52 a.m., the Committee was adjourned.]

Committee on the Budget
Hearing on Health Care and the Budget: Issues and Challenges for Reform
June 21, 2007
Statement of Senator Sheldon Whitehouse

I want first to thank Chairman Conrad for holding this hearing, and for his longstanding interest in the ways in which health care reform can significantly improve America's fiscal outlook for decades to come.

Our health care system is broken: it yields unsatisfactory results at vast expense. The annual cost of the system exceeds $2 trillion and is expected soon to double. We spend more of our GDP on health care than any other industrialized country. Health care is one of the largest expenses for many of our companies: Starbucks spends more on health care than it does on coffee beans and Ford spends more on it than it does on steel.

Yet the number of uninsured Americans is climbing and will soon break 50 million. As many as 100,000 Americans are killed every year by unnecessary and avoidable medical errors. Life expectancy, obesity rates, and infant mortality rates are much worse than they should be, by most international measures. The system itself doesn't work – hospitals are broke, doctors are furious, and paperwork chokes the system. More American families are bankrupted by health care costs than any other cause.

I have heard from countless Rhode Islanders who have struggled to pay for their health care, and who live in fear of losing the coverage on which they and their families depend. It does not have to be this way.

What we are dealing with, in a nutshell, is market failure: the American health eare system does not optimize quality or invest in prevention, particularly where improved care would lower cost; the system does not have the information technology infrastructure to support the improvements we need; and the way we pay for health care sends adverse price signals that steer away from the public interest.

Specifically in the area of health information technology, some pretty respectable organizations have looked to see what we would save in health care costs if our health IT infrastructure were adequate. Here's what they report for anticipated savings:

- RAND, $81 billion, conservatively;
- David Brailer, former National Coordinator for Health Information Technology, $100 billion; and
- The Center for Information Technology Leadership, $77 billion.

The average of the three estimates: $86 billion per year.

That is a lot of savings to leave sitting out there – savings desperately needed by American businesses and American families.

But rather than a focused national effort to capture the savings from health care reform, the system leaves it up to individual doctors and health care providers to choose and implement health IT infrastructure office by office. If you were in business school and you submitted that structure as a business plan for health care reform, you'd not only get an F, you might be asked to reconsider your career path.

We have work to do in three areas: improving health care quality and prevention in ways that lower costs; fixing our information technology to increase efficiency and generate savings; and repairing the reimbursement system so it does not discourage those reforms, but rather encourages and rewards them.

A few weeks ago, I introduced three bills to address these problems. The Quality Reform Expansion and Savings Act of 2007 (S. 1451) would provide grants to local quality reform organizations that are engaged in the real "R&D" work on improving care and lowering cost in health care.

The National Health Information Technology and Privacy Advancement Act of 2007 (S. 1455) would create a national, private, non-profit corporation to plan, initiate, develop, finance, and manage our national IT infrastructure. I want to note especially that the funding mechanism for this bill allows the corporation to capitalize on the billions of dollars in projected savings for health information technology, raising revenue through user fees, bonds, and other appropriate tools without increasing the deficit.

Finally, the Improved Medical Decision Incentive Act of 2007 (S. 1471) would allow doctors and medical specialty groups to apply to their state departments of health with best practices, and to reward them for compliance with such protocols through increased public insurance payments and speedier private payments.

The system that underlies all our health care financing, coverage, and access problems in this country is itself broken. It is administrative and bureaucratic machinery, and, like other machinery, when it is broken, it needs to be fixed.

Fixing the administration of our health care system will reduce costs, improve care, and make a badly-operating system run better. That can move us a critical step forward towards making sure every American family has access to health care they can afford.

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Senator Russell D. Feingold
Opening Statement
June 21, 2007
Health Care Reform and the Budget

I thank the Chairman for holding this hearing today. I would also like to thank Dr. Orszag for being here. I am pleased that the committee is focusing on health care reform today. I often say that when I travel to each of Wisconsin's 72 counties each year, health care is virtually always the number one topic. It's the number one topic in my state, and one of the most important in the country, yet Congress does not reflect the urgency that I hear in the voices of my constituents. I commend Chairman Conrad for responding to the importance of this issue by holding a series of hearings on health care reform, and I am pleased to be here for this first hearing in the series, which will provide an opportunity to look at practical ways of reforming our health care system and the impact on our country's budget.

There are many problems in our health care system that I think are overdue in receiving proper attention, and these issues converge with the problem of the uninsured. Health care costs are driven up, hospitals and clinics are overburdened, and communities and families struggle all as a result of uninsurance. There are over 45 million people in the United States without insurance, and this number grows steadily. Congress can address this problem; we just need to figure out a way of moving forward that overcomes the political deadlock that has stopped this

body from acting.

We need a way to break that deadlock, and that is why I have introduced a bill with another Senator on this Committee, Lindsey Graham. Last month we introduced the State-Based Health Care Reform Act, which will give select states funding and authority to cover the uninsured within their state and in doing so, help move the country toward reform.

This bill makes political sense because it capitalizes on initiatives we have seen in states like Massachusetts, Illinois, California, and Wisconsin. It does not prejudge the type of reform that a state should adopt. Additionally, the proposal makes fiscal sense. This bill provides up to $40 billion for states to use for reforms, and it is entirely offset. If passed, this would provide a path to nationwide health care reform while still maintaining budget neutrality. I look forward to hearing Dr. Orszag's thoughts on a state-based approach as well as his thoughts on a fiscally responsible approach to health care reform.

Senator Graham and I are from opposite ends of the political spectrum, we're from different areas of the country, and we have different views on health care. But we agree that something needs to be done about health care in our country.

The United States is the only industrialized nation that does not guarantee health

care for its citizens. It is unacceptable for a nation as great as America to not provide good health care for all our citizens. We can do better.

I look forward to discussing this approach further and to hearing about other health care issues important to my colleagues and to Dr. Orszag.

HEALTH CARE AND THE BUDGET: THE HEALTHY AMERICANS ACT AND OTHER OPTIONS FOR REFORM

TUESDAY, JUNE 26, 2007

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The Committee met, pursuant to notice, at 9:32 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Kent Conrad, Chairman of the Committee, presiding.

Present: Senators Conrad, Wyden, Nelson, Stabenow, Cardin, Whitehouse, Gregg, Allard, and Crapo.

Staff present: Mary Naylor, Majority Staff Director; and Scott Gudes, Staff Director for the Majority.

OPENING STATEMENT OF CHAIRMAN CONRAD

Chairman CONRAD. The hearing will come to order.

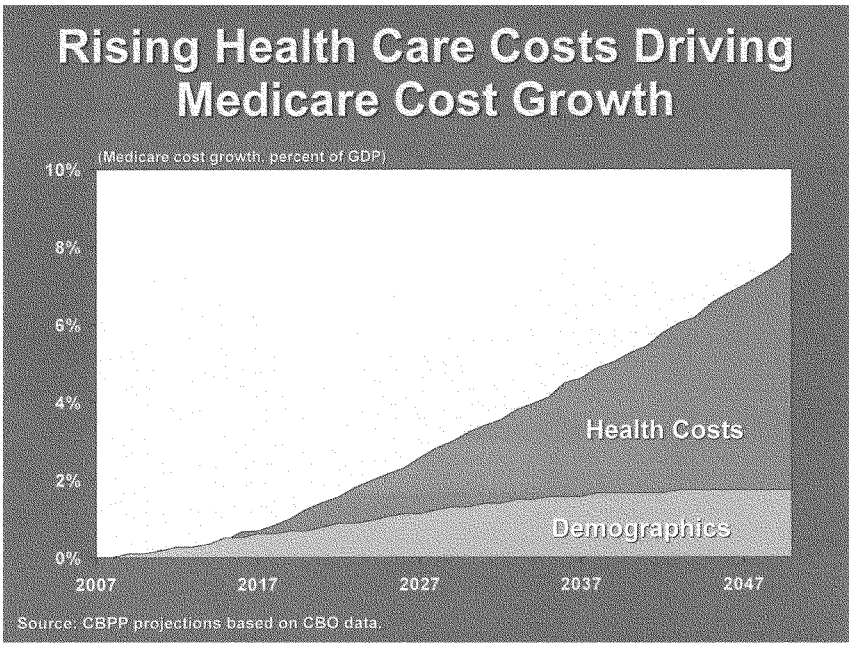
I want to welcome everyone to today's hearing. This is our second hearing this summer on health care reform and the impact on the budget. Last week our witness was the CBO Director, Dr. Orszag, who helped set the stage by providing an overview of the problem and issues to consider in evaluating reform options.

Today we will focus more specifically on comprehensive solutions and the issues raised by them. We have two panels today. Our first includes two of our most respected colleagues: Senator Wyden, who is a valued member of this Committee; and Senator Robert Bennett, who is a longtime leader on the Joint Economic Committee. Senators Wyden and Bennett will jointly present their Healthy Americans Act.

I want to first commend them for working together. That is going to be critically important as we approach the issue of health care reform and all of the other contentious issues facing us on fiscal policy.

Our second panel includes three health care experts, Len Nichols, Director of Health Policy at the New America Foundation; Sara Collins, the Assistant Vice President of the Program on the Future of Health Insurance at the Commonwealth Fund; and Arnold Milstein, the Medical Director of the Pacific Business Health Group. These experts will be giving us their views on health care and options for comprehensive reform.

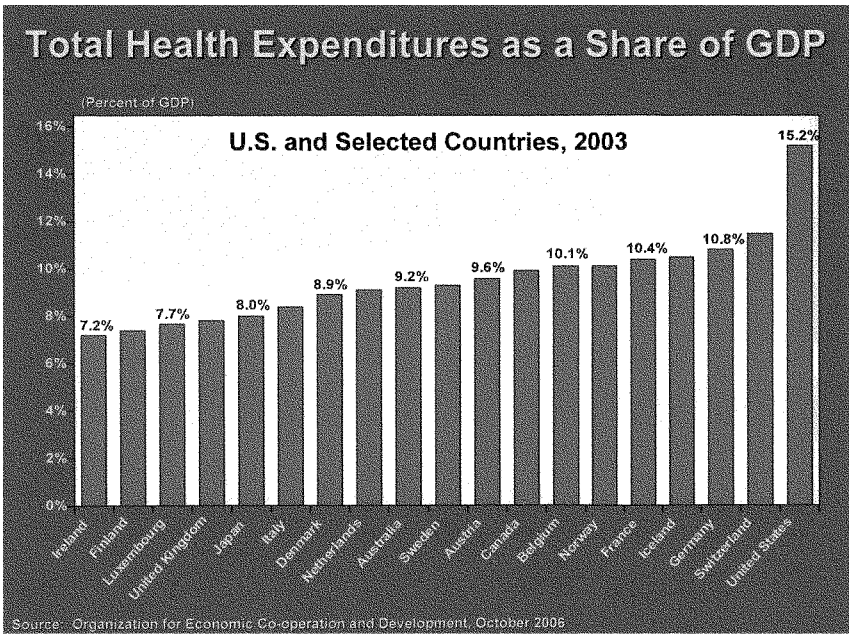
I want to begin with this chart that shows that rising health care costs are by far the largest factor driving up the cost of our Federal health programs.


Rising Health Care Costs Driving Medicare Cost Growth
(Medicare cost growth, percent of GDP)
10%
8%
6%
4%
2%
0%
Health Costs
Demographics
2007
2017
2027
2037
2047
Source: CBPP projections based on CBO data.

Demographic changes that we all know about and that have been so much in the news are also a significant factor.

But the biggest factor, the largest element here, are rising health care costs in the larger system.

Let me go to the next slide, if we could.


Total Health Expenditures as a Share of GDP
(Percent of GDP)
U.S. and Selected Countries, 2003
16%
14%
12%
10%
8%
6%
4%
2%
0%
7.2%
7.7%
8.0%
8.9%
9.2%
9.6%
10.1%
10.4%
10.8%
15.2%
Ireland
Finland
Luxembourg
United Kingdom
Japan
Italy
Denmark
Netherlands
Australia
Sweden
Austria
Canada
Belgium
Norway
France
Iceland
Germany
Switzerland
United States
Source: Organization for Economic Co-operation and Development, October 2006

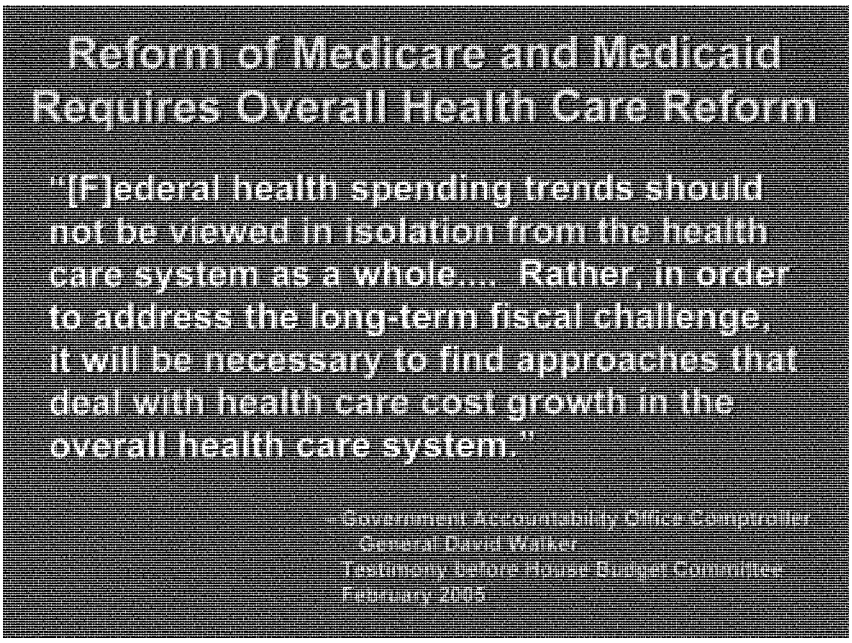
The fact is that our health care system is not as efficient as it could be. We are spending far more on health expenditures as a percentage of GDP than any other country in the world. This chart goes back to 2003. For those who are wondering why do we go back to 2003 and 2007, it is because it is the most recent year for which we have comparative data from other countries.

We know our own health care expenditures now are over 16 percent of gross domestic product. That means that about one in every seven dollars in this economy is going to health care and that percentage is rising.

If we look at other countries, we see the next highest country in terms of expenditure per share of GDP is at 11 percent. So one would assume that because we have the highest health care expenditures in the world we have the best health care in the world. Unfortunately, we know that that is not the case.

In fact, what we see is in many cases health care expenditures are inverse to health care outcomes. In other words, higher health care expenditures do not lead to better health care outcomes. In fact, in many parts of this country, the places that are the highest cost health care have the lowest quality health care outcomes.

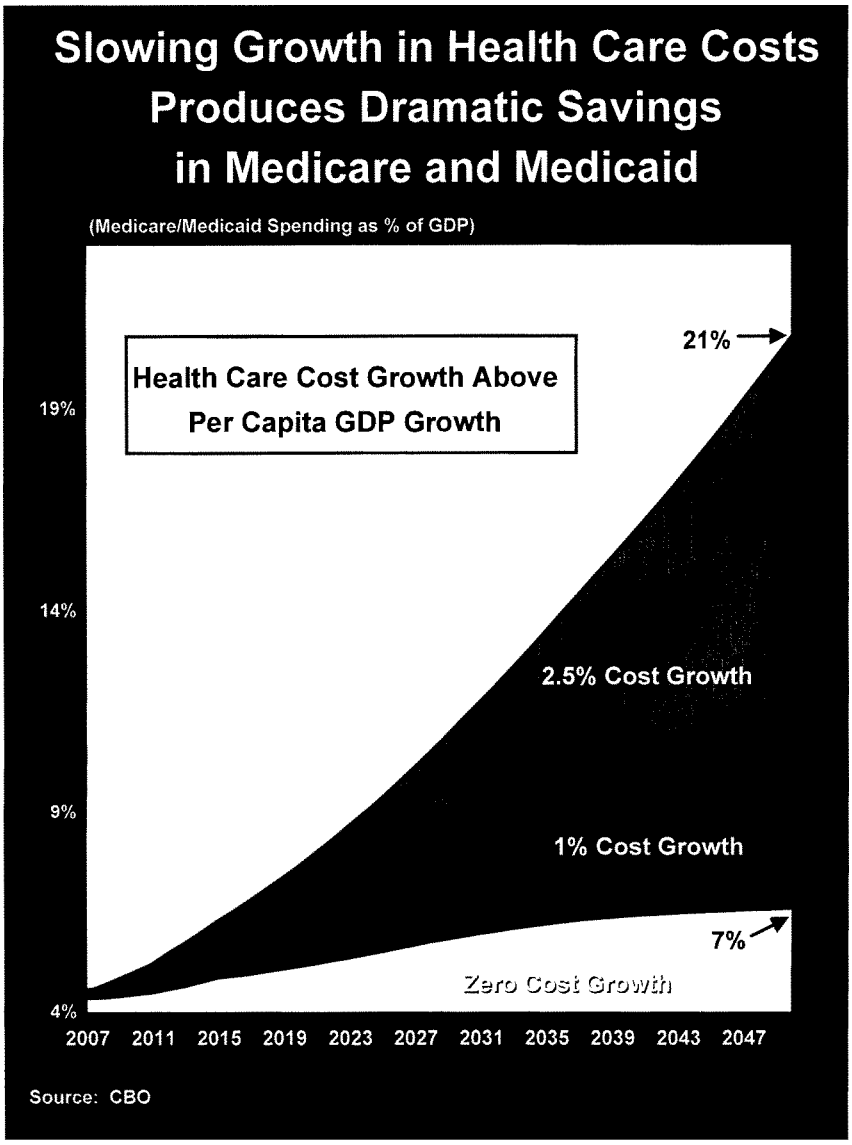
Let us go to the next slide, if we could.


Reform of Medicare and Medicaid Requires Overall Health Care Reform
"[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole.... Rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system."
– Government Accountability Office Comptroller General David Walker
Testimony before House Budget Committee
February 2005

We need to remember the problem is not that Medicare and Medicaid are Federal programs. The problem stems from the rising cost of health care and the demographic tsunami that is coming at us. This is a quote from the Comptroller General of the United States, David Walker, who made this point: "Federal health spending trends should not be viewed in isolation from the health care system as a whole...Rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system."

Let us go to the next slide, if we could.

Let us go over that one, in the interest of time. Senator Gregg is now here, let's just go to the final one.


Slowing Growth in Health Care Costs Produces Dramatic Savings in Medicare and Medicaid
(Medicare/Medicaid Spending as % of GDP)
Health Care Cost Growth Above Per Capita GDP Growth
21%
19%
14%
9%
4%
2.5% Cost Growth
1% Cost Growth
7%
Zero Cost Growth
2007 2011 2015 2019 2023 2027 2031 2035 2039 2043 2047
Source: CBO

The fact is that we can get dramatic savings in Federal health care programs if we can reduce the rising cost of health care. This chart shows that reducing per capita annual health care cost growth from 2.5 percent above GDP to 1 percent above GDP can bring down Medicare and Medicaid spending as a percentage of GDP from 21 percent in 2050, to under 12 percent in that same year.

Look, we all know we have a huge challenge here. The 800-pound gorilla is health care expenditures. That is what can swamp the whole boat here. And we know that if we get to 2050 and we are spending over 20 percent of GDP on just Medicare and Medicaid, that is more than we are spending on all of the Federal Government today. That cannot be permitted to occur.

The question is what do we about it? That is what this series of hearings are about. I again want to thank our colleagues, Senator Wyden and Senator Bennett, for their thoughtful approach to the issue and for their leadership.

Senator GREGG.

OPENING STATEMENT OF RANKING MEMBER GREGG

Senator GREGG. Thank you, Mr. Chairman. I want to express my appreciation for you holding this hearing because really, as Willie Sutton used to say about why he robbed banks, that is where the money is. This is where the money is. This is where the problem is. And it is where the money is. And it is where the threat is to the next generation.

I assume you held up the chart before I got here that pointed out that there is about $30-plus trillion of unfunded liabilities simply in the Medicare accounts and that will bankrupt the next generation if we do not do something about it.

The issue becomes not finding new revenue streams to support it, because it is really not supportable or sustainable. The issue is how you control the rate of growth to get it back to a number which is more reflective of the number you have mentioned, which is something nearer to the rate of inflation for the economy as a whole.

And that becomes an issue of a variety of different initiatives that have to be taken. There is no magic wand here that can solve the whole problem. It is a matrix and a complex matrix, and you have to move forward in a number of different areas: health IT, transparency, market-oriented approaches so people are more cost sensitive when they are purchasing, quality information, making sure that there is a consistency of quality and a consistency of cost across the country relative to quality, and cost and procedures.

And so it is a complex issue. And I appreciate the effort the two senators before us today have made in this area, Senator Wyden and Senator Bennett. Obviously it is a good memo to begin the discussion with and I look forward to hearing from them.

Chairman CONRAD. Thank you, Senator Gregg.

Let me say to the Senator, I did not hold up that particular chart this morning. But really, as I look ahead to the budget and fiscal challenges facing the country, none loom larger than this one. And that is why I think it is critically important that we start this series of hearings and talk about what are we going to do about it?

What are the potential solutions? All of us know there are a lot of ideas out there. We want to try to find the best ones.

Certainly one of the best is the one advanced by our two colleagues who are here this morning. Senator Wyden, who I have indicated earlier is a valuable member of this Committee; Senator Bennett, who is widely respected and esteemed for his views on economic and financial matters, welcome to the Committee. Senator Wyden, why don't you proceed.

STATEMENT OF HON. WYDEN, A UNITED STATES SENATOR FROM THE STATE OF OREGON

Senator WYDEN. Thank you very much, Mr. Chairman.

I want to thank you and Senator Gregg for having Senator Bennett and I this morning. This is an exceptionally busy time here in the Senate and once again you have shown your commitment to finally getting our arms around the health care challenge.

I know all of you, and Senator Cardin who spent a lot of time on health care over the years as well, are going to have folks pulling on you extensively. So I would like to just make my prepared remarks a part of the record and offer up just some brief comments with respect to where I think we are.

Mr. Chairman, we have only been at the cause of fixing health care in this country for about 60 years. It goes back to Harry Truman in 1945, the 81st Congress. And so I think the first thing people are going to say is what is different about this time? Why do you think there is grounds for optimism today?

I think there are three big factors. First, the business community has done a complete about-face on this issue. Back in 1993, for example, during the Clinton debate, the business community said we cannot afford health care reform. Now they are saying we cannot afford the status quo. That is No. 1.

No. 2, there are new alliances that have formed that we certainly did not see in 1993. When we proposed the Healthy Americans Act, for example, standing next to us was Andy Stern, the Head of the Service Employees International Union, and Steve Burd, the President of the Safeway Company. So 12 or 13 years ago they belonged to groups that were fighting each other. And now they are stating there side-by-side saying they want to work for a specific piece of legislation.

And finally, as Senator Bennett and I will tell you, I think there has been something of an ideological truce in the last few years. Republicans have come around to the proposition that you cannot fix health care unless you cover everybody. Because if you do not cover everybody the people who are uninsured shift their bills over to folks who are insured.

Democrats have come a big distance as well, recognizing that you cannot just turn all of this over to the Government and have a Government-run system. And you particularly have to make changes in the tax code because the tax code disproportionately favors the wealthiest and promotes inefficiency.

The bumping up against those positive signs, of course, is the popular wisdom. The popular wisdom is oh, this is too big. It is too complicated. Congress cannot possibly get its arms around something this size. People say there are too many lobbyists. They say

people who have coverage, for example, the millions who have coverage are still going to say the devil that they know is better than the devil that they do not know. So the popular wisdom kind of bumps up against the very positive signs we are seeing.

So I think what is helpful about your hearing, Senator Conrad, is it gives us a chance to diagnose what is really broken in health care and then get at the cure. I am going to do the diagnosis very quickly.

First, I strongly share your view that we are spending enough money on health care today. We are going to spend $2.3 trillion on health care. There are 300 million of us. You divide $300 million dollars into $2.3 trillion and you could go out and hire a doctor for every seven families in the United States, pay the doctor $20,000. And whenever I mention it to the doctors they say Ron, where do I go to get my seven families? I would like to be a doctor again. We are spending enough money, colleagues. We are not spending it in the right places.

Second, as you touched on, Chairman Conrad, we are not getting collective value for the amount of money we are spending. And that is despite the thousands of wonderful doctors and nurses and physician assistants. In spite of all this talent, I think the latest numbers, for example in life expectancy, we have surged ahead of Cuba and Albania but we still lag behind Malta. So we are not getting as much as we ought to get in terms of collective value.

Finally, on the diagnosis side, is we have mostly stick care. We do not have health care. We do not have prevention. Medicare, for example, pays huge expenses for hospital bills under Part A. And then Medicare Part B pays very little for prevention. So Senator Bennett and I want to get us back in the business of health care and not just sick care.

So that is my diagnosis. Let me move on to the cure and go through briefly what I think the citizens want by way of a cure.

In my town hall meetings, after we have a bit of discussion and people say they want a Government-run health system and other folks they know they do not, people in the audience eventually say Senator, we you want coverage like you people have in the U.S. Congress. And then the whole room breaks out into applause. People are not exactly sure what Members of Congress have but they figure if they have it, it is a good thing.

So what I do at that point, Mr. Chairman, is I reach in back and get out my wallet and I go all right, let us be clear about what it is Members of Congress have. And so at my town meetings I hold up on this. This is my BlueCross card. It is a private policy, a private insurance policy. And Senator Bennett and I feel that we ought to have a system that makes it possible for all Americans to have a private insurance card and to choose from a range of policies.

And the Lewin Group, which is something of the gold standard of private health coverage, has done an analysis for us. We have made it available to the Committee. It says for the amount of money we are spending, everybody in the United States could have choices like Members of Congress have, private coverage like Members of Congress have, and a delivery system like Members of Congress have.

So here is the way it works. We have 300 million people in the United States. Senator Bennett and I are saying that the basic structure of Medicare and the military system ought to be left intact. So we would like to make some improvements. For example, we have rewards for prevention, improving chronic care, something called a health care home. Mr. Chairman, the typical Medicare patient sees seven doctors in a typical year. So we ought to have better coordination of their care.

But Senator Bennett and I leave the basic structure of Medicare and the military system alone.

So that leaves us then 250 million people. About 160 million of those get their care through their employer, about 48 million are uninsured, and the rest are primarily in the individual market, or Medicaid. So here is what we do for this group of people: for the 160 million who are covered by their employer, we say the employer ought to cash them out. And do it in a way so that the employer wins and the worker wins with the very first paychecks that are issued. So hypothetically, if you have a worker in North Dakota who would make $40,000 and would get $10,000 in health care benefits from their employer, the employer would give them $50,000. The worker has just gotten a big old pay raise and says to themselves hey, that is pretty neat. What is the catch? The catch is that they have to buy a basic health policy.

Workers may say how in the world do I do that?

So Senator Bennett and I fixed the private marketplace. We say that insurance companies can no longer cherry pick, for example. They cannot just take the healthy people and send the sick people over to Government programs more fragile than they are. And then we adjust the tax laws so that the worker does not pay more tax on that additional compensation that they got from the employer.

Now the next group, small business in particular, where most of the uninsured are, usually in a situation where the employers are dying to cover their workers but have not been able financially to figure out a way for them to do it.

So we worked with three groups of employers: big employers, medium-sized employers, and small employers. And all of them agreed that they could pay something. They could pay something. And so they make a contribution on the basis of revenue per employee. So those who are uninsured and work at small business get their coverage that way. In the individual market it works along the same lines. People in the individual market use a State agency to sign up. It is close to home. It simplifies the process. So that works for most of the folks that are uninsured.

With respect to Medicaid, we have made improvements so that the program is more efficient and more compassionate. Today on Medicaid, you have to try to squeeze yourself into scores of boxes. In my state it is more than 30 boxes you have to try to squeeze yourself into to get some coverage. It is a horrendous waste of money. It is degrading for poor people. And so we make coverage more efficient and more compassionate and say you sign up once through these State agencies and everything else is done through electronic transfers. The Lewin Group has found substantial savings as a result of our doing it.

Let me wrap up by saying where the money comes from in terms of paying for it. We redirect the tax code expenditures. Instead of what we have today that disproportionately favors the most affluent and encourages inefficiency, we redirect those expenditures and get more help to folks in the middle and folks in the lower middle classes so they can buy these private coverages. We make substantial administrative savings that the Lewin Group has documented. I will not go through all of them, Mr. Chairman, because the time is short. They are outlined on page 15 and 16 of the Lewin report that we have made available to you.

We make savings in what is called the disproportionate share program, where a lot of poor folks go to hospitals and hospital emergency rooms where we would rather have them get private coverage that is outpatient oriented.

When insurance companies compete on the basis of price, benefit, and quality there are savings in that area. And as I touched on, we make savings in Medicaid by making the program more efficient while we also make it more compassionate.

Finally, Mr. Chairman, we want to have a broad berth for the States. Senator Bennett and I have had some very good discussions with Secretary Leavitt on this point. The Healthy Americans Act makes it possible for the States to get a waiver to come up with their own approaches. We also same for purposes of the benefit package there can be what we call an actuarial equivalent offered, so that there is a lot of flexibility there for the States and private insurers.

At the end of the day, Mr. Chairman, I would like to see us on a bipartisan basis work to defy the odds and produce a rational system so that everybody gets quality affordable coverage in this Congress.

I know people say it cannot be done. We are all aware of that debate, that this is kind of a Presidential election issue. I do not think the American people sent us here to wait two more years. That is what we would be doing. We would be waiting two more years, essentially until the middle of 2009. And I do not think the country can afford to wait.

Senator Bennett and I have the first bipartisan overhaul of health care since the one offered by the late John Chafee. We are not saying it is set in stone. Quite the contrary. We know that nothing is invented here. You have to work with colleagues on a bipartisan basis. But we think we ought to get going.

[The prepared statement of Senator Wyden follows:]

U.S. Senator Ron Wyden

Prepared Testimony Before the

Senate Budget Committee
Hearing, "Health Care and the Budget: The Healthy Americans Act and Other Options for Reform"

June 26, 2007

Mr. Chairman and Members of the Committee, I welcome the opportunity to testify before you today on S. 334, "The Healthy Americans Act" and look forward to hearing from my co-sponsor and the panel of national experts gathered here today. Mr. Chairman, I wish to particularly thank you for your leadership in turning this committee's attention to the challenges in our health care system, as well as for arranging the opportunity to hear from the co-sponsors and experts concerning this proposal today.

As you may know, this is the first comprehensive, bipartisan Congressional proposal to overhaul the health care system in nearly fifteen years. This is also the first Congressional hearing on a piece of comprehensive health care reform legislation since 1994. During the intervening thirteen years, Americans have seen their health coverage grow more expensive and less secure. While the U.S. system affords many Americans access to cutting edge technologies and cures, it faces several serious challenges. The problem can be summed up with three "c's" of Cost, Coverage and quality of Care.

Our proposal contains the tools to tackle each of these difficulties head-on. The Healthy Americans Act holds down growth in health care costs, covers every American and improves care with a new emphasis on prevention and wellness.

The U.S. currently spends $2.3 trillion—over 15% of our GDP—on health care and these expenditures are projected to reach 20% by 2016. The U.S. spends well above other OECD countries, including those countries whose systems include a significant role for private health insurance, such as in Switzerland, the Netherlands and Germany, who spend 11.6%, 9.2% and 10.9% of their respective GDPs on health care. In last week's testimony, Congressional Budget Office Director, Dr. Peter Orszag, testified before this Committee. The CBO Director underscored the need to act broadly-- the U.S. is only going to gain control of public health spending if policymakers find ways to address cost growth in the system in its entirety.

Despite its high price tag the system doesn't cover 45 million Americans ---an increase of 6.3 million non-elderly adults from 2000. If you look back 2 decades, to 1988, we see that the number of uninsured has grown by about 14 million, from 31.1 million in 1988. Why this coverage decline? Rising costs clearly play a role in this as they make it harder for employers to offer, and for individuals to buy, health care coverage.

Both parts of the private system—the individual and employer market—are serving fewer and fewer Americans. Sixty-one percent of non-elderly Americans had employer coverage in 2004, down from 66% in 2000. The percent of firms offering health benefits to at least some employees has fallen from 69% in 2000 to 61% today. In simple terms, the employer-based system is melting like a popsicle in August. The individual market covers only 17 million non-elderly Americans—or 6.7% of the population. Less healthy Americans find it harder and harder to find coverage as insurers can "cherry-pick" who they cover in most states and also charge higher premiums to those with chronic or expensive health conditions.

Furthermore, Americans don't really have a "health care" system, but rather have a "sick care" system. Three-quarters of health expenditures go towards chronic conditions without making sufficient investment in preventing these conditions or managing them more effectively. In addition, there are a lot of avoidable medical errors and better information systems could help solve this problem.

So how can Congress help Americans improve the system? The answer to that question comes from my town meetings where I asked people what they wanted in health care. They say, "Ron, we want what you people in Congress have." Our proposal, the "Healthy Americans Act" does just that. It provides coverage for all Americans with benefits like members of Congress have *without costing more money.* It even saves money. It takes employers out of the business of providing health care coverage so that they can better compete in the global marketplace. All Americans are required to purchase an individual policy; those with low-incomes receive a sliding scale subsidy to help them buy coverage. Employers make a contribution, depending upon their size and revenue.

The Healthy Americans Act takes away some of the hidden and poorly targeted tax subsidies in the current system and distributes them more broadly across the system. Now, if you are wealthy, you can write off costs of a designer smile; if you are a minimum wage worker working at a corner furniture store, you get nothing. Employer plans receive generous federal tax benefits—irrespective of whether they provide "barebones," minimal coverage, or an extremely generous "Cadillac" package.

The Lewin Group, an independent non-partisan health care consulting group that is the "gold standard" in its field, has analyzed the proposal and found that it is possible to provide that guarantee for the $2.3 trillion now spent annually and even save $4.5 billion in health spending the first year and almost $1.5 trillion over the next decade. The Lewin Group also studied the Act for the Commonwealth Fund and found that under our proposal, family health spending would decline by $78.8 billion—with the greatest reduction in spending benefiting lower and moderate income households.

It should be of particular interest to the Budget Committee that our plan is the first health reform proposal to lower the rate of growth in health spending. Lowering health spending will help keep down costs of Federal entitlement programs which are currently projected to skyrocket in the coming decades. If health care costs continued growing at the same rate over the next four decades as they did over the past four decades, CBO estimates that federal spending on Medicare and Medicaid alone would rise to about 20 percent of gross domestic product (GDP) by 2050—roughly the share of the economy now accounted for by the entire federal budget.

The savings in our plan come from changes that make the system more efficient and equitable: 1) tax code changes; 2) administrative savings; 3) making insurers compete on price, benefits and quality; 4) disproportionate share costs for hospitals; and 5) making care for the poor more efficient—instead of running a separate health care system for low income people, they would have private insurance policies with Medicaid as a wrap-around.

Under the Healthy Americans Act, public programs would no longer provide health coverage for low-income people. With most low-income people getting private insurance coverage instead of being in government programs, the bureaucracies that administer these programs can be eliminated or substantially reduced, which means savings to the taxpayers.

Our bill also puts a special emphasis on creating a new culture of wellness and addresses the fact that America doesn't have health care at all -- we have sick care. A prime example is Medicare. Medicare will spend thousands of dollars under Part A for senior citizens' hospital bills and virtually nothing under Part B for prevention to keep people well. The Healthy Americans Act creates incentives for seniors to take proactive steps to improve their health by giving them a break on their Part B premiums if they lower their blood pressure, cholesterol, stop smoking or improve their health in other ways. Over time, this emphasis on preventive care will help hold down costs by lessening the need for more costly hospital treatment.

The Healthy Americans Act does borrow some elements from other countries that provide universal coverage while dipping less into their GDP than the U.S. No one country has a system that the U.S. could or should "import" to help solve its health care woes. Germany requires both employers and employees to contribute to their health care coverage---so does the Healthy Americans Act. In Switzerland, each person must buy a private individual health insurance policy--our proposal requires this as well. Switzerland and the Netherlands impose rules to ensure that private insurers cannot "cherry-pick" and compete based upon their benefits, quality and price—the Healthy Americans Act does this as well.

The Healthy Americans Act provides a uniquely American solution AND reflects the fact that both Republicans and Democrats had it right. Republicans had it right that the government shouldn't run all of health care and so the Act continues to have the private insurance market play an important role. Democrats were right that the system needs to cover everyone, both from a moral perspective, as well as to avoid the kind of cost-shifting and productivity losses caused by uninsurance. I hope that this hearing marks the beginning of a concerted action to move forward on comprehensive reform during this Congress. Thank you again for this opportunity.

Chairman CONRAD. Thank you, Senator Wyden.

Senator Gregg has to go to the floor momentarily, but I think he would like to ask a question.

Senator GREGG. I just had one question of the Senators, because I have read your proposal. It is intriguing.

If I can try to sugar it off and summarize it, is essentially what you are doing is you are taking the deception which is now at the employer level and you are converting that deduction to cash into the hands of the employee. And then you are saying to the employee go out and buy insurance.

It is, for all intents and purposes, a voucher program. You are basically converting the insurance market where you give everybody a chit backed up by cash. And you say you have to buy insurance and the insurance has to meet certain standards as to community rating and it has to have certain levels of coverages such as the FEHBP level.

Senator WYDEN. Let's not characterize anything as a voucher, because that will be the kiss of death. I would describe what we are doing with the cash out as a transition way to get to a new system.

And by the way——

Senator GREGG. Let me see if I have it right, though. You are giving people cash, people then take the cash and buy a plan and the plan is subject——

Senator BENNETT. You are not giving them cash because it is a tax credit that is only available for a particular purpose. If you were giving them cash, they could go out and buy a new set of tires for their pickup.

Senator GREGG. That is my point. That is why I called them a voucher because you are essentially giving them a ticket which says you have to go buy insurance with this money that you are getting back from the employer in the form of compensation. Right? I mean, does that summarize it?

Senator WYDEN. In the old days, people got vouchers and they would march around town with a piece of paper that said this entitles you to such and such. There is not going to be anything like that. We are going to have to figure out a way, Senator, to make a transition from what we have to something else.

Senator GREGG. No, you are basically mandating that they go out and buy the insurance.

Senator BENNETT. There is an individual mandate, that is correct.

Senator GREGG. So the individual has to use the proceeds that they are getting from their employer, who is no longer having a deductible event for insurance, that is converted to a payment to the employee. The payment then must be used or some percentage of it must be used to buy insurance, which insurance has to be community rated and it has to have a certain set of benefits which are at least the minimum of the FEHBP program.

Senator BENNETT. That is correct.

Senator GREGG. I appreciate it. I guess my only concern, and I am sorry I have to leave, is I think it is an intriguing idea, quite honestly, and probably the right way to move.

I think the next step, however, is how do you build in efficiency? What do you make that buy—what incentives do you give that

newly empowered individual with this cash—not called a voucher—to go out and use it in a way that is market oriented and efficient and gives them good health care at a lower cost?

Senator BENNETT. We will be glad to discuss that with you.

Senator WYDEN. Before the Senator runs out the door, what we have picked up from the Lewin people and others, I would say to my friend, is once that person has the extra money in their pocket and has choices for their health care, because remember today the worker largely has no choice. The worker just gets the one policy that their employer has for them.

Once the worker has those choices, if say in the example I gave where the worker would get a certain amount because of what their employer is paying, they then look for a variety of different choices. And if they save $500 on that, they can go fishing on the Rogue River in Oregon.

Senator GREGG. That, I think, is a key element of the program. Interesting idea.

Chairman CONRAD. I want to thank Senator Gregg. I know that he is got duties on the floor.

Senator Bennett, welcome. Please proceed.

STATEMENT OF HON. ROBERT F. BENNETT, A UNITED STATES SENATOR FROM THE STATE OF UTAH

Senator BENNETT. Thank you, sir.

I want to thank you for holding the hearing and for your leadership role in focusing Congress's attention on health care reform.

I especially want to thank my colleague and fellow panelist, Senator Wyden, for his leadership. And along with leadership, which is a word we throw around a great deal here, he brings vision and passion to this which, in many cases, is more important.

I believe the Congress needs to address health care reform this session and not put it off for future Congresses. More importantly, I believe that it can. That is because our conversation starts with what we can agree on, where we can find consensus. And we will find the common ground necessary to pass comprehensive health care. And because I believe that, I have joined with Senator Wyden and cosponsoring the Healthy Americans Act.

This Congress is uniquely situated in history. For the first time since Dwight Eisenhower's election there is not an incumbent in the White House running for the White House, neither a sitting president nor a sitting vice president. And yet you have divided government. The Democrats controlling the Congress have a political motive to accomplish big things. And the Republicans want to have a legacy come out of this Administration but they cannot take credit for it for their candidate because their candidate will not come from this Administration.

So these are rare circumstances of a political setting that creates the ideal time for Congress to act in a bipartisan way on comprehensive health reform.

Now, we have established some principles we can agree on. And here they are in my view: tax reform, portability, individual access, incentives for healthy behavior, and market forces. The Healthy Americans Act embodies these five tenets of reform. It is not a per-

fect bill but I think it is a perfect jumpstart to begin the dialog about these core principles. So let us go through each one of them.

Tax Reform. We all agree that the rate of growth in health care spending in our country is unsustainable. For the last 45 years in the United States health care as a part of the gross domestic product has more than tripled to 16 percent. It is on a steady climb upwards. As you have pointed out, Mr. Chairman, other countries have a much smaller rate of growth of percentage of GDP devoted to health care and they have drastically lower numbers of uninsured.

I look at it and realize that as the amount of money spent per capita rises, out-of-pocket expenditures of after-tax dollars by individuals are decreasing equally if not more dramatically. Which means that Americans have little or no knowledge of how much their health care costs or where their health care dollars are spent because they do not control those dollars. It is the employers who are spending their employees' money.

By giving employees the right to control their own dollars the Healthy Americans Act will strengthen the incentives to shop for lower-cost plans as well as improve quality.

Portability. Because individuals do not receive any tax incentive for obtaining health care coverage outside the employer setting, they feel chained to their jobs many times. Americans should not have to be afraid to change jobs just because they fear losing access to health care coverage. It is not good for productivity. It is not good for the rest of the economy. And it is certainly not good for the person who is trapped in a job that he or she hates. There needs to be portability in the health care system so that individuals will always have their coverage regardless of where they work. The Healthy Americans Act provides portability.

Individual access. Every American should have access to health care. In fact, currently every American does. It is called the emergency room. And that is the most ineffective, inefficient, and expensive way of care possible. If all Americans have their own individual portable coverage, the uninsured will no longer engage in overutilization of emergency room visits, health care spending will be more evenly dispersed and dramatically reduced. The Healthy Americans Act provides individual access.

Healthy behavior. Healthy individuals use less health care dollars than unhealthy ones and the record is very good that when people spend time taking care of themselves health care costs go down dramatically. In private industry there are multiple examples of companies that have aggressively pursued keeping their employees healthy and, as a result, their health care costs increases are level to inflation or in some cases even below it.

Healthy behavior incentives are working in some other countries around the world. For example, in Switzerland, where only 11 percent of GDP is spent on health care and everyone is required to purchase his own private plan—similar to the Healthy Americans Act—competition has lead to innovative incentives to stay well. Some plans offer lump sum cash awards for those who stay healthy and others penalize unhealthy habits or behaviors. People respond to incentives. And if there are incentives for individuals to stay

healthy, we will see significant differences in driving down health care costs.

The Healthy Americans Act promotes personal responsibility and prevention by offering discounted premiums for participation in wellness programs and rewarding providers for helping their patients stay healthy.

Market forces. When transparency and competition exist, markets work. But markets require transparency on cost and quality to work efficiently. Once the individual is empowered to make choices, he or she will demand such transparency and market forces and competition will enter and work their magic. As seen in the Swiss model, private sector competition drives down costs and offers innovative solutions.

It all starts with tax reform, Mr. Chairman. We get the right kind of tax reform. That will empower the individual. And from that empowerment we can get portability, individual access, incentives for healthy behavior, and the beneficial effect of market forces.

Healthy Americans Act embraces these five principles so that health coverage can be affordable, and the uninsured can be covered, and not insignificantly our economy can be strengthened.

I thank my friend from Oregon for inviting me to serve as his Republican cosponsor. I hope to work with members of both parties closely on this issue and I think we can craft reasonable legislation that provides access to health care to all Americans.

Chairman CONRAD. Thank you, Senator Bennett. Thank you, Senator Wyden, for your testimony.

Let me just say, and I know Senator Bennett has to take his leave momentarily. I think you have the basic structure right. That is my own conclusion. After 20 years in this business, and I was deeply involved in the efforts when we had the mainstream forum with Senator Chafee and Senator Durenberger, we spent hundreds of hours trying to craft a health care reform package.

Unfortunately those efforts came to naught. But I do believe you have the basic structure right. That is this is not Government controlled but there is a role for Government. You have universal coverage and I think most of us now acknowledge that if you do not have everybody in the system then you just have leakage and you have transfer pricing. You have transfer of cost going on throughout the system. And unfortunately, the transfer occurs at the most expensive point of the system which is, as Senator Bennett indicated, the emergency room.

You build on what we have. We have a system now that, in fact, does insure a significant majority of people, although a growing number of people are not.

You provide portability. Senator Bennett, you said it very well. In many cases, people feel locked to their job. I have relatives that are in that very situation, a relative who is an extremely productive and successful executive in the health care profession. And his wife has an ongoing chronic illness and he feels wedded to his job because of the health care coverage circumstance.

Incentives for healthy behavior. If there is one thing that is clear it is we have the incentives wrong in this system. We incentivize

treatments. And boy, if you incentivize treatments, you get a lot of them. Whether or not they are efficacious is another issue.

Chronic care coordination. This, I believe, is an area that you address that we could strengthen in a final proposal. The statistic that always captures my attention is about 5 percent of Medicare beneficiaries are using half the money. We have to focus on that like a laser.

And then market forces. Clearly, if we could harness market forces we could bring greater efficiency to this system.

Now with that said, the devil is in the details. I think all of us recognize that. There are two I want to just visit with you about momentarily.

Senator BENNETT. May I be excused?

Chairman CONRAD. Yes, Senator Bennett.

Senator BENNETT. I am ranking member of a Committee that is holding a hearing, so I probably ought to run to that.

Chairman CONRAD. We understand.

Senator BENNETT. I will read your details with great interest, Mr. Chairman.

Chairman CONRAD. Thank you so much, Senator Bennett, for being here. Again, these two Senators are two of the most respected of our colleagues. When they speak on a subject, we listen.

Let me, if I could, ask Senator Wyden just on two details.

Senator WYDEN. Only two?

Chairman CONRAD. Yes, I will limit myself to two. The two I would ask you about one, who decides on the package of what is required for an employee to use the money that comes from their employer? Who decides what has to be in a minimum package?

Senator WYDEN. That was a very important question, Mr. Chairman. That is why I was saying in a kidding way, as we get into the details, there are scores and scores of them and time does not allow us to get at all of them.

We had a big debate about how to set the minimum benefit package. So essentially we got into a two-part exercise. Because citizens at these town hall meetings always say we want care like you people get, we essentially took, as a minimum benefit package, the middle range benefit package that is available to Members of Congress. In other words, there are half of them above and half of them below. It is sort of the middle range. In the Lewin report it is outlined. It has prevention, outpatient, inpatient, and catastrophic——

Chairman CONRAD. Let me ask this, would the BlueCross BlueShield standard option, would that be——

Senator WYDEN. Right. That could certainly be one of them.

Chairman CONRAD. That is what many of us have. I have people ask me all the time, they think we have some great Cadillac plan here. It is a good plan. But what many of us have is a BlueCross BlueShield standard option that is widely available in our States.

Senator WYDEN. It is what I have with the card I held up.

And then we took another step and we said it would also be possible for plans to offer what would be called the actuarial equivalent, so that it would be a lot of flexibility for innovation and creative kind of thinking.

And then we also said, because none of this ought to be set in stone, that we would lay out a process so that after we had this underway for a couple of years there would be a commission, an advisory group that would in effect look at whether—we got into this with Dr. Orszag, for example, last week, whether as a result of comparative effectiveness changes that there ought to be an adjustments in it as we go along.

But at some point you have to figure out how to set that minimum benefit package. That is how we went about doing it.

Chairman CONRAD. The second question I had, and just briefly, is on the pay for side of the ledger. You cash out the—as I understand it, the employer cashes out the employee. If he is spending $10,000 a year on the health care of that employee, that $10,000 is made available to the employee for the purpose of buying a health care policy.

Senator WYDEN. Correct.

Chairman CONRAD. If the employee is able to save money and able to get a policy, to get that standard option, whatever it is, mid-range of what Federal employees have, and it only cost them $8,000, what happens to the savings? The $2,000 savings?

Senator WYDEN. They, of course, are allowed to keep it. I do not think we will see many people getting it for $8,000. I think we are more likely, particularly at the outset since this is a basic package, for them as a result of the fact that they will have more choices in the marketplace, one. The marketplace will be fixed because insurance companies will not be able to cherry pick. They will compete on the basis of price, benefit, and quality. My guess is that a good shopper along the lines of what you are talking about might save $500 or something along those lines.

And that is why I joked they will get to go fishing in Oregon.

But the point is that there will be incentives——

Chairman CONRAD. Now a North Dakotan, would they have to go all the way out to Oregon to go fishing?

Senator WYDEN. We will work out an agreement with Senator Crapo and Senator Stabenow and our colleagues on that.

Chairman CONRAD. We have very good fishing in North Dakota. I am there.

Senator WYDEN. That is essentially the outline. I do not think people, in the instance of buying that $10,000 policy, are immediately going to save $2,000 on a basic package. But they might save a few hundred. And that begins to kick in the kinds of incentives that we do not have today, where you essentially go out on your own in this broken marketplace that has all this cherry picking, they are not much interested in you. And if you have an employer-based plan, you basically get the one thing that the employer gives you and that is it.

Chairman CONRAD. I am going to stop at this point because there are other members here. Let me ask, Senator Wyden, would you be open to questions from other members of the panel? As we set this up we indicated only the Chairman and ranking member would ask.

Senator WYDEN. Sure. Of course.

Chairman CONRAD. But I would just make this offer to members of the Committee. If they would have questions for Senator Wyden,

we will have one 5 minute round because we have a second panel. And you can either use that time to ask questions of Senator Wyden or make a statement.

Senator Cardin was first.

Senator CARDIN. Thank you very much, Mr. Chairman, and let me congratulate Senator Wyden for not only his legislation but his leadership on the health care issues. He has been a champion for many years. And we appreciate that you are working with Senator Bennett because I do agree, we need to have a bipartisan approach if we are going to be able to get results in this Congress. And we need to get results.

I also agree that we are spending enough money. Both you and the Chairman have indicated that. But the problem is we have 46 million to 48 million people without health insurance. We talk about those numbers but let me just put a face on it. Deamonte Driver, a 12-year-old from Prince Georges County, Maryland, fell through the cracks. Had Medicaid, lost Medicaid, had no insurance, had a toothache. A simple toothache, tooth decay.

His mother thought his younger brother was in worse shape than he was with oral health care. Deamonte ended up going to the emergency room, where they have to treat him. A quarter of a million dollars was spent on emergency surgery. And he lost his life through an abscessed tooth going to his brain.

For an $80 tooth extraction, we could have saved his life.

So each one of these 48 million represent an individual family. And we all have lists on what we need to do to improve our health care system, bring down costs, including taking on the prescription drug cost and dealing with preventive health care and dealing with long-term care and dealing with use of technology more effectively. But No. 1 should be, on everyone's list, universal health coverage. We have to get everyone in the system. That is what you said, and I agree with you completely. We have to get everyone into the system.

In 1993, I was on the Ways and Means Committee, the Subcommittee on Health. I not only supported the Clinton approach for universal coverage, I voted for it in the subcommittee. It has been to long until we get back to a way to get universal coverage.

So I start off by congratulating you for bringing forward a proposal that will bring us to universal coverage, because we need to do it in a proposal that I hope that this Congress will consider the proposals for universal coverage.

I just caution that—I listened to your explanation and I thought you did an excellent job. But whenever you have a proposal that is somewhat complex, people will pick at it. That was one of the problems we had in 1993.

I am working on a proposal that takes part of what you just said in your proposal. It is a rather simple bill, I hope to file it shortly, that will require every person in this country to have health insurance. A simple individual mandate. Allowing the States to determine what is an acceptable product and the enforcement being the cost to provide a minimum insurance plan in your State.

So that everybody would have health insurance in this country, be required to have health insurance. I think it would be the right steps to take to encourage those States that are already moving

forward with universal coverage to show that the Federal Government wants to be a partner in that approach.

I think it helps employers who want to cover their employees, looking for more options, because I think the private insurance marketplace would provide more opportunities knowing that the market is going to be a lot larger. And it certainly helps individuals today who go into the insurance market to try to find an insurance product and cannot find an affordable product because, as you point out, adverse risk selection and cherry picking. If everyone needed insurance, there would certainly be more products available. And it would also encourage those young workers who today choose not to buy insurance, who have the opportunity, knowing that it is required, I think you will see a more favorable way of moving forward.

Senator Wyden, I just really wanted to take this time to applaud you and agree with you that we need to take up health insurance in this Congress.

Mr. Chairman, it would be a mistake for us to wait two more years. And I am more than happy to get your reaction, but I really believe that you are on the right track by placing the responsibility at least first that everybody in this country must have insurance, must be part of the system.

Senator WYDEN. Just very quickly, if I could, Mr. Chairman. I do not want to make this a bouquet tossing contest. But we are just thrilled to have Senator Cardin here. He and I have been working on health care since the days when he was on the Ways and Means Committee. Just a couple of quick reactions.

First, on this issue of being complicated, and I think one of the reasons that we took the time this morning is we wanted to lay out how it would work for 300 million people. I have tested this at town meetings. And I hold up that card and I say you are going to get choices like Members of Congress get, a delivery system like Members of Congress get, and I can lay it out in just a minute or two. And I think that will be part of the effort to prevent what the Senator is talking about. Because, of course, all of this can be twisted around.

It also allows us to say there is a precedent. Everybody always wants to say well, how do we know it works? We can say Members of Congress and their families are not complaining.

With respect to the cost, my hope when we shipped this off to the Lewin people, and they been scoring for everybody, the Administration and us and everybody else, is I said I hope we get to revenue neutrality. I hope we can just tell people it will not cost more than we are spending today.

And when they came back and said at the outset you can expand the coverage for less money and save close to $1.5 trillion over 10 years, I just about fell off my chair. I had no idea that we would be able to get to that point. And I still say to myself if we can get close to that, I think we would be in a position to move a bipartisan piece of legislation.

So the Senator is right. I also want to add I very much share your view about the need for a wide berth for the States. That is going to be very key. Senator Bennett and I have been talking to

Secretary Leavitt about that and we will definitely want to have discussions with you about it.

Senator CARDIN. Thank you. Thank you, Mr. Chairman.

Chairman CONRAD. I thank Senator Cardin.

Let me just indicate to the audience that there are chairs up in front. There are a lot of people who have been standing for some time in the back. There are at least four chairs up in the front, three on this side and on over here. Please feel free to take those chairs.

Senator CRAPO.

Senator CRAPO. Thank you very much, Mr. Chairman. I appreciate you holding this hearing.

Senator Wyden, I am not going to ask you a question. I am just going to make a comment and then you can reply to it if you would like.

But I just want to thank you for efforts in this area. I apologize I did not get here for your original testimony so this may have already been stated. But as you know very well, with your leadership, a group of senators on both the Republican and Democrat side have come together to commit to try to get past the partisan differences and the philosophical battles that we have had for decades now, trying to resolve these issues of getting an adequate and not only an adequate but a top-notch health care system in place in this country.

Five Republicans and five Democrats have signed a letter to the President. I am one of those, working with you, telling the President that we are ready to sit down and hammer out a solution because our country so badly needs that kind of leadership. And so I appreciate your leadership in that area.

We really do need to get past the conflicts in the past that have stopped us, frankly, from proceeding. In a very shorthand way of looking at it, there are those in the country and in Congress who want to have a Government-run health care system, what some of us call a purely socialized health care system, one where the sole provider is the Government and we get away from market forces and trying to figure out how to let a market work.

There are others in Congress who want none of that and they want to have a pure market system in which we move away from all of the other aspects of assisted health care that we have.

And in the middle is sort of the uneasy mix that we have right now, which is a little bit of a win for one side and a little bit of a win for the other side over the years as we have battled back and forth here in Congress.

The solution clearly, in my opinion, is not one which is well thought out. It is time for us to come together and work on a bipartisan basis to solve the problems that we have in our health care delivery system in this country.

And so I applaud you. I look forward to working with you to achieve these objectives. It is going to require that we all give and that we all take. The give and take is going to necessarily result in some kind of a compromise where, in this traditional battle that we have over how to handle our health care, neither one side nor the other is going to come out of the total victor. I am confident that it will be some kind of a mix.

But we have to come together and find a path forward that reaches solutions. And you certainly have started to put your finger on some of the directions in that pathway that we need to be traveling.

So I commend you for it and thank you.

Senator WYDEN. I would just say I really appreciate the Senator's involvement. Before the Senator got here I talked about, even in the letter, the sort of ideological truce. As we talked about when we were doing the letter, and the Chairman was involved in this, it is a big lift for some folks on the Republican side to say we are going to cover everybody. We are going to get everybody under the tent. But it was a big lift for some of the folks on the Democratic side to talk about the role for the private sector we did, and talk about fixing the tax code.

So your involvement has been a great help and we are appreciative.

Senator CRAPO. Thank you.

Chairman CONRAD. Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

I would like to start by emphasizing what Senator Cardin and Senator Crapo have just said, which I agree with very, very strongly. And that is that the health care situation is very dire and our health care system right now is, in effect, broken. And if your car was broken, you would take it and get it fixed. And you would not care whether your mechanic was a Democrat or a Republican. You would just get the work done.

Same with your plumbing. You do not care about your plumber's political views. You just need somebody who can make the darn thing work better.

And that is where I think we are in health care. So these initiatives to try to get away from—there are plenty of partisan dynamics in this building, and some of them are wonderful. But this is an area where we really need to push toward solutions. So I appreciate, Senator Wyden, what you are doing.

In terms of trying to put it into some context, I would hypothesize to you that we have a finance problem in the health care sector. I hesitate to even call it a system. That is a complement to it that it does not deserve.

But if it were a system, it would have a finance aspect to it. It would also have an operations aspect to it. In a business you will often see that there is a finance group that deals with the financial problems. And then there is an operations group that deals with the operations problem.

As you know, I am focused a lot on the operations piece and I see quality reform, particularly in those proven areas, particularly in Senator Stabenow's State of Michigan where a wonderful example took place, saving $165 million just in 15 months, just in intensive care units, and not even all of them while saving nearly 1,600 lives. There are these win-win situations out there where people get better health care at lower cost.

We have a disastrous health information technology system. It is the second worst of any industry except the mining industry, according to the Economist magazine. The available savings accord-

ing to RAND, as you know, are between $81 billion and $346 billion a year.

And then, of course, we have some really idiotic and counter-productive price signals in the way the reimbursement system is going.

I see those three elements as being kind of core principles for solving what I call the operations problems that we have in the health care system. And I would like your comment, Senator, because you have thought about this a long time and are one of our leaders here in the Senate on this issue, about the extent to which you would agree that the plan you are discussing here is primarily a financing plan and the extent to which you would find that to create any conflict with the sort of operational level reforms in quality institute, in quality care, in health information technology, and in reimbursement reform that I know you are also very interested in.

In a nutshell, do you think those two initiatives can proceed in happy concert with each other and in parallel?

Senator WYDEN. I think the Senator has made important points. I do see this as considerably more than a financing proposal. For example, this is the first proposal that goes right to the heart of changing behavior in this country. This is the first time anybody has said, under Medicare Part B, let us make it attractive for prevention. So we say there would be voluntary incentives. If seniors lower their blood pressure, lower their cholesterol, they get lower premiums. This has brought together conservatives who want to look at health care from a behavioral standpoint and folks on the liberal side who see this as an important expansion as it relates to benefits.

So I do see this as considerably more then a financing issue.

I think what the Senator is talking about with respect to information technology, and our friend from Michigan has talked about, is extraordinarily important. There are two points that come to mind.

One of the areas we touched on last week with Dr. Orszag, and the Chairman got into this, is some of the most important work in this area, particularly as it relates to information technology, prevention, and comparative effectiveness where you are kind of looking at one approach versus another in terms of treating a patient. Traditionally the Congressional Budget Office has not been willing to score as something that will save money.

Everybody in the country, Democrats and Republicans, know that it will save money. But the people who are deputized to make these official scores have not scored it to date. And that is why Lewin, with the important things we did in prevention, and we used the Agency for Health Care Quality Research to do some of the work the Senator is talking about.

Lewin, when we had discussions with them, they sort of smiled and said those are great ideas, all you people in Congress have them, put them in. We are not going to score them. We are not going to score that they make any savings, even though you and others argue for the fact that prevention will surely pay off, as will information technology.

Now that we have you here in the U.S. Senate to lead us on information technology, and we are looking at your very good bills, because I think they make a big contribution, we are going to want to bring those into this debate, as well. And I think your touching on sort of the financing and the operations of health care is critically important.

What we tried to do is to say look, the system today does not work. It does not work in the financing area. It does not work in prevention. It does not work in information technology. We require, and the insurance companies have indicated, they would go along with this, that when somebody signs up for a plan that an electronic medical record is opened on them at that time and people would own their record so we could have the portability.

But there is a lot of heavy lifting to do and we are glad you are here to help us in so many of the important areas.

Senator WHITEHOUSE. Thank you.

Chairman CONRAD. I thank the Senator.

Senator ALLARD.

Let me also indicate the situation we are dealing with here. One of our witnesses on the next panel has to leave by 11 o'clock. So after Senator Allard and Senator Stabenow have had their turn we will then call the second panel. and I will ask Dr. Milstein to go first to the second panel because he has another time constraint, and I apologize to everyone else but we have to try to make this work for everyone.

Senator ALLARD.

Senator ALLARD. Thank you, Mr. Chairman. And thank you for holding this hearing. Senator Wyden, thank you for your leadership on this very important issue.

You are working, I guess, with Senator Bennett on this proposal. I think that is an appropriate individual to be working with. The fact that he has a health care systems in Utah that is doing a fabulous job of holding physicians accountable, and I will go into that. Maybe you are aware of it but I will mention it to you.

But I have served on the health board at the county level. I have served in the State Senate in Colorado, served in the U.S. House, served here in the Senate, and been on committees in each one of those bodies that talked about health care.

Obviously preventive medicine is something that helps. Then there is things that you can do for holding the programs more accountable. Is basically more rules and regulations. But we have a fundamental problem with third-party pay. That is the patient or whoever pays into the third party, they think they paid for health care. And then the insurance company or the Government or whoever is paying out to the physician, they do not have the time or the effort that individuals should be putting out to hold whoever the provider is accountable.

And they have, with Intermountain Health Care System, where they have gone to electronic records. You and I have talked a little bit about electronic records and we know how important electronic records are as far as a diagnostic tool. But they are using electronic records in a way where they are using an outcome based evaluation for the doctors.

So this is a system that has, I do not remember how many doctors they have in it, but we will just pick a figure, somewhere around 500. And they look at those doctors, for example, who are treating diabetes. I am using this hypothetically.

So they will look at some of the doctors. Some of them have a better recovery, a quicker recovery rate and maintenance of glucose sugar than others, and do not have as many secondary complications as others. So then what they do is they look well, this doctor here is getting these kind of results and this is what is happening in the end. And the other doctors getting other results but they are not as favorable as the first doctor.

So then they say well, what is this doctor doing that the other ones are not? And since they are all in this group together, they have a conference and say look, we have to talk about this. There is this discrepancy.

What they have found in this program, and they have the facts to prove it, is they are bringing in the quality of care because the doctors, and they graduate from a whole different variety of medical institutions, they all have their approach to treating diseases. And they are working out, through their organization, processes that work best for the State of Utah. This is a Utah—it is called Intermountain.

Dr. Brent Jones of the Intermountain Health Care is the one that I got this presentation on. I have heard lots of presentations, but this is the one that has hit me as being the most effective in holding down health care costs and improving the results at the end because it is sort of an outcome based measurement of the various strategies that doctors use in a practice.

I just bring that to your attention and just wanted to give you an opportunity to maybe comment on it. I am glad you are working with Senator Bennett because this is an organization that is right in his back door and maybe both of you have been visiting with this organization. But they have some good things.

Senator WYDEN. I think the person you are talking about, Brent James, in particular, he is on our citizens health care working group that Senator Hatch and I were involved in getting set up. He really has been the gold standard in terms of trying to integrate the kinds of services that you have mentioned. We are trying to essentially build on it. There are a handful of programs like that in this country.

In my part of the world Kaiser, for example, has tried to do much of the same thing that Intermountain has.

But the Senator is absolutely right, there are some very good models that we ought to look to.

Senator ALLARD. Thank you, Mr. Chairman.

Chairman CONRAD. I thank the senator.

Now I will turn to Senator Stabenow. I will just point out Senator Stabenow was reminding us all forcefully in the last few weeks that this health care issue goes way beyond the health care part of our economy and affects the manufacturing sector. I remember very well the Senator telling me in this country we have about $1,500 of embedded health care cost in every automobile. And our competitors, less than $100. That confers an enormous economic

advantage on our international competitors in the automobile industry.

So Senator Stabenow, who has been such an important part of this Committee in dealing with health care issues, glad you are here this morning.

Senator STABENOW. Thank you, Mr. Chairman, for this additional hearing that is so critical. And thank you for raising what is, in fact, an international competitiveness issue for us in terms of keeping jobs in America. As I know Senator Wyden knows, as well as being, in my opinion, the No. 1 quality-of-life issue for all of us.

I am really pleased, first of all, that we have been talking about health IT as it relates to saving dollars, comparative quality issues, as Senator Allard raised. There is such a wide range of issues that can be addressed through health IT.

I hope that we are going to begin to move on that as a piece in conjunction with the broader issue as soon as possible because it is going to take time to get that set up. And we are now in agreement with the fact that it needs to happen. Now we just need to move ahead and help providers be able to put it in place so we can use it.

Senator Wyden, thank you so much for your thoughtfulness and your leadership on this issue and so many areas of health care.

Focusing on prevention, I totally agree with you on the fact that there is enough money in the system if we were using it correctly, more than enough, to be able to address the uninsured and bring down costs.

What I grapple with all of the time, and I would appreciate your thoughts on this, and I apologize for having come in late to your presentation. But when we talk about an individual mandate, I understand the concept of an individual mandate. We hear often of an individual mandate that you have to get auto insurance or you have to get homeowners insurance. The difference is you do not have to have a car, you do not have to have a house. That is part of the costs you build it. But we are all stuck with our bodies and so it is tough to say we will choose not to get sick.

For me the question is always, I understand the theory of more people going into the marketplace. That makes sense to me. But what I am concerned about is what happens on the insurance end to make sure that people can actually afford to purchase that insurance. Because now you have more people in a mandate. How do we know, first of all, that it just will not be a terribly confusing situation, as has happened with other things for people? And how do we know that, in fact, that costs will really come down for people in that mandate?

That is where I get stuck. We say to people you have to have it. I understand that we would no longer see cherry picking, which is a really important thing. But if you could speak on the insurance end, what kind of reforms, what kind of consumer protections do you see? For me that is critical in getting my arms around this.

Senator WYDEN. The Senator, as usual, makes a very important point. Of course, if you do not make—and it is really a good one to quit on, Mr. Chairman, because let us talk about how it would work in the real world.

What Senator Bennett and I are trying to do, and I held up my private card, is make it look like it works for the Stabenow family. What happens to the Stabenow family and the Whitehouse family and all of us is you get that information from a variety of private insurers during the open enrollment season. They are required to offer explanations and to have toll-free lines and the kind of thing that allows you to have a place to answer questions. For our proposal we use State agencies. We call them health help so that there would be, for example, a Midwestern health help. You might have just for Michigan or for a handful of states in Michigan. They can help walk people through the choices.

The cash out feature is very important because when this goes into effect the first thing people are going to say is how in the world am I going to do this? So we put the extra money in people's pockets so that they are in a position to then have the money to make the choices.

Now we think if we can enforce the insurance reforms, and the Senator is absolutely right, this does not work unless you reform the insurance sector. I have told insurance companies, and we had a visionary insurance leader, a BlueCross leader from our area, Mark Gansle [ph], you give and you get. You are going to have to give on things you have resisted in the past. There is going to be guaranteed issue so people can get coverage. You cannot discriminate against people with pre-existing illnesses. There is going to be loss ratio requirements so that what you get in the premium dollar you have to pay out. Insurance companies do a lot of gulping when you talk about all of the things that you are going to require in terms of consumer protection.

But then you tell them hey look, you are not going to get put out of business. Some people think that we ought to just had this over to the Government. You are not going to be put out of business.

So the Senator is absolutely right. The linchpin of going to something like this for our country is making sure you have these private insurance reforms which, if coupled with the tax code changes so you do not disproportionately favor the most affluent, we can make it work. Those are the two things. Stop rewarding the wealthiest among us under the Federal health care tax rules and make the private insurance reforms that the Senator eloquently has talked about. Then I think you make it work for the families we all care about.

Senator STABENOW. Thank you.

Chairman CONRAD. Thank you, Senator. It is a good place to end it.

Senator Wyden, I want to thank you and Senator Bennett for your appearance here today. You have contributed significantly to the work of this Committee and certainly beyond the borders of this Committee, as well, to the work of the Congress.

We may have an opportunity because SCHIP is up for reauthorization. Maybe we need to think more broadly. That is, of course, providing health care coverage to children. We have a debate going on right now whether adults should be covered under SCHIP.

I have argued if you are going to cover adults you have to call it something else. You cannot call it health care coverage for children.

Maybe we need to lift our horizons here and talk about not just additional incentives for covering children. Maybe we need to have this broader discussion of how we cover everyone in this country and do it now.

Senator WYDEN. Sign me up, Mr. Chairman.

Chairman CONRAD. You have certainly done an enormous amount of work and we very much appreciate the energy and the effort that you have put into it.

Thank you, Senator Wyden.

Senator WYDEN. Thank you.

Chairman CONRAD. I now call the second panel. Sara Collins, the Assistant Vice President on the Future of Health Insurance at the Commonwealth Fund; Len Nichols, Director of Health Policy at the New America Foundation; and Arnold Milstein, the Medical Director of the Pacific Business Health Group.

Thank you all for being here.

We are going to go immediately to your opening statements and we are going to start with Dr. Milstein because I know he is under a severe time constraint and has another obligation that will require him to leave, as I understand it, at about 11 o'clock.

First of all, I want to thank all of the witnesses for being here. I appreciate it very much. And as we are getting set up, I hope we can turn to Dr. Milstein for his testimony and then we will proceed with the other witnesses.

Dr. Milstein, welcome.

STATEMENT OF ARNOLD MILSTEIN, M.D., MEDICAL DIRECTOR, PACIFIC BUSINESS HEALTH GROUP

Dr. MILSTEIN. Thank you, Mr. Chairman.

My testimony can be reduced to three key points. First, health care reforms should initially include a focus on removal of the 30 to 40 percent waste in current health care delivery. This waste is about equally divided between services of no valuable and valuable services that fail to meet low-cost benchmarks per unit of service. These inefficiencies were described in an Institute of Medicine report published in the fall of 2005 along with this estimate of 30 to 40 percent waste in current spending.

This is a critical place for health care reform to focus because greater efficiency of health care delivery frees up funds to widen health insurance coverage and, equally important, enable greater investment in quality of care so we can begin to create more distance between our quality rating and those of countries like Albania.

Second, that highest leverage point for eliminating this estimated 30 to 40 percent waste is by motivating physicians to conserve health care resources and to deliver quality at levels already being achieved in their communities by their peers who are at benchmark levels of efficiency and quality.

I did bring along one slide that illustrates, just gives you a pictorial image of what happens in any given community when one profiles, compares individual doctors on two dimensions. The vertical dimension illustrated in this diagram is quality of care, rate of compliance with evidence-based guidelines. And the horizontal axis is what I refer to as the average health insurance fuel

burn per episode of care. So it is total all-in costs associated with a particular physician's care.

A number of pioneering purchasers, in this case a partnership between the machinists union and Boeing, have begun to pioneer in generating such comparisons among physicians in a community. Each one of these little dots is a doctor in the Seattle area.

In essence, if one models how much could be saved if simply every doctor in Seattle practiced at the level of the low-cost high-quality benchmark doctors, which is illustrated by the northeast quadrant in this distribution, the savings would be substantial, on the order of magnitude of 15 percentage points in total spending while improving quality.

The next slide simply summarizes some of the experience of a few early purchaser pioneers who have taken advantage of this to share with both physicians and consumers differences in physician performance within a community associated with both resource use and quality. You can see this is a mixed group of users. It includes very progressive and forward thinking labor unions like the hotel workers union in Nevada, a number of health insurers and self-ensured employers like Pitney Bowes. As you can see, the early returns on this, when used by single payers, is on the order of magnitude of two to 17 points, depending on how aggressively the results are used.

Why physicians? Why focus on physicians? Physicians are the highest leverage point on both quality and efficient resource use because State laws give them the exclusive authority to write orders for medical services that comprise more than 80 percent of total health insurance spending. And because no one influences patient health behaviors more than physicians do.

The third point is that to adequately apply strength to this leverage point Congress should consider authorizing use of reports from analysis of the Medicare claims data to help all private payers to identify and reward physician excellence more accurately. Very few self-insured employers, union-administered health benefit plans, or insurers have sufficient density of insurance claims data to compare accurately and reward physicians on conservative resource use and achieving benchmark levels of quality. Most payers simply do not have sufficient density of claims data in any given community to do this.

The Medicare data base is the only health insurance claims data base in the U.S. of sufficient size to enable all private payers to generate performance measures at the individual physician level.

Senators Gregg and Clinton have proposed to correct this problem via the Medicare Quality Enhancement Act at no cost to the Federal Government. It is supported by a very wide variety of constituents, including AARP and virtually every labor organization and large employer that is aware of the legislation has signed on in support of it.

If Congress enacts it, it would potentially enable all payers to slow per capita spending growth, improve quality of care and—importantly for this hearing—help fund wider health insurance coverage.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Milstein follows:]

Catalyzing a Better, Leaner

American Health Care System

Employers, Unions, Insurers, and Consumer Organizations Could Greatly Improve Health Insurance Affordability and Quality via Improved Physician Performance Transparency; Access to Measurements of Physician Performance Based on Analysis of CMS Claims Data is Pivotal; Medicare's Sustainability Would Also Improve

Testimony of Arnold Milstein MD, MPH

Senate Budget Committee

June 26, 2007

I am Arnold Milstein, Chief Physician at Mercer Health & Benefits and the Medical Director of the Pacific Business Group on Health (PBGH), which serves over 50 large California employers. My testimony incorporates my work with employer-funded health benefits plans operating in Nevada, Washington, Massachusetts, and California. It does not represent the positions of these organizations.

As American employers, unions, and taxpayers struggle to tame a long-standing 2.5 real percentage point gap between annual health care spending growth and GDP growth, one tool of great power remains widely unused: the measurement of individual physicians' and physician groups' relative propensity to consume health insurance "fuel" when treating an episode of acute illness (such as a broken leg) or a year of chronic illness (such as advanced diabetes). Other terms for this dimension of physician performance are "total cost of care," "all-in cost," "longitudinal cost-efficiency," or more simply "relative affordability."

After adjusting for differences in the mix and severity of illness that they treat, physicians in the same community and same medical specialty typically vary by roughly 2X in the average total dollar amount of health insurance "fuel" that they "consume" per episode of treatment. This inter-physician variation in health insurance fuel consumption is not exclusively driven by differences in physician fees or in the volume of services provided directly by a physician. Rather, it is due to differences in the many factors that physicians influence through their uniquely powerful role in recommending or incurring office visits, drugs, imaging studies, lab tests, specialist consultation, hospitalizations, and healthy behaviors. Today, the practice pattern

of more affordable physicians consumes the equivalent of 30 miles per gallon of health insurance fuel; others function as the medical equivalent of large SUVs. These affordability differences do not correlate with quality of care. Attachment A demonstrates in an illustrative community this wide difference in physician-associated health insurance fuel consumption. *Variation in affordability of physician practice patterns persists at every level of measured quality of care.*

Most physicians are unaware of the relative affordability of their pattern of practice. When physicians' relative affordability is measured, payers can use the results in four ways to encourage physician improvement. Arranged roughly in ascending order of their likely power to improve affordability, these uses are:

A.	FEEDBACK FOR MD USE IN PERFORMANCE IMPROVEMENT	Sharing affordability and quality measures with physicians and relying on their professionalism to improve the affordability and quality of their practice pattern, as was advocated for Medicare by MedPAC in 2005.
B.	PUBLIC TRANSPARENCY	Publicly releasing affordability measures, along with quality measures, so that consumers may select more affordable, high quality physicians.
C.	PAY-FOR-PERFORMANCE	Using affordability measures, along with quality measures, in physician pay-for-performance programs.
D.	PHYSICIAN NETWORK NARROWING OR TIERING	Using affordability measures to create insurance products that reward consumers with lower cost-sharing if they select more affordable, high quality physicians.

Critics of physician affordability measures reasonably question whether a physician's affordability score primarily reflects differences in (a) patients' severity of illness, health behaviors, or health care preferences; (b) the accuracy/completeness of claims data submitted by physicians; or (c) the impact of other providers. To answer this question, a number of employers, union-administered multi-employer benefits trusts and insurers have applied the ultimate test of the validity of such measures: they incentivized their enrollees to switch to quality-credentialed physicians who scored in the more affordable range (method D, above), and then measured whether per person health care spending growth slowed compared to other insurance plans in the same local area. In Attachment B, I have summarized their results: in brief, *all achieved substantial savings,* roughly in proportion to their degree of physician selectivity and salience to local physicians.

Other private sector health benefit plan sponsors are beginning to follow these pioneers. For example, Wellpoint in California is now offering a PPO plan based on a network of more affordable, quality-credentialed physicians. Its premiums are on average 9% lower than for its less selective PPO plan. However, *very few private sector health plans have enough claims experience to measure with confidence the affordability or quality for a majority of individual physicians in a community.* This leaves private sector health benefits plan sponsors with unattractive choices: (a) select physicians from among a minority of physicians with whom they do have enough claims experience; (b) select physicians based on marginal or outdated claims experience; or (c) merge claims data with other insurers. Due to inter-payer differences in claims data bases and anti-trust concerns, option (c) is very difficult and slow. That said, under the leadership of the Massachusetts state employee benefits plan, "the GIC," six of Massachusetts's seven largest insurers merged their claims data and measured individual physician affordability and quality statewide in consultation with the Massachusetts Medical Society. Health insurers began offering less costly new plans to GIC members in July 2006, based on preferential use of more affordable physicians with favorable quality scores. In other states, over 50 large employers and 6 partnering multi-state insurers participate in "Care Focused Purchasing." CFP is pursuing a claims data merger that will enable similar solutions in multiple urban areas effective January 1, 2008. HHS' BQI ("Better Quality Information") initiative will document the feasibility of merging of regional CMS and private sector claims data bases, in partnership with CMS, AHRQ and other organizations, including PBGH. However none of these pioneering efforts offer a near-term national private sector alternative to the three unattractive choices (a) – (c) described above.

Private sector progress could be greatly accelerated if CMS routinely made available the Medicare claims data base to a small number of qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This has been proposed in the Medicare Quality Enhancement Act – S.1544 sponsored by Senators Gregg and Clinton. Except for pediatric and maternity care, the Act would enable employer-sponsored and individually sponsored health benefits plans to lower premiums and raise quality of care via all four methods A-D listed on page 2, above. The single permitted use of the data would be to generate health care performance measurements, based on the aggregated claims of multiple beneficiaries. This approach to CMS claims data availability has been supported by the *New York Times* editorial board, the Business Roundtable, the SEIU, AARP, the American Federation of Teachers, and other diverse purchaser and national consumer organizations.

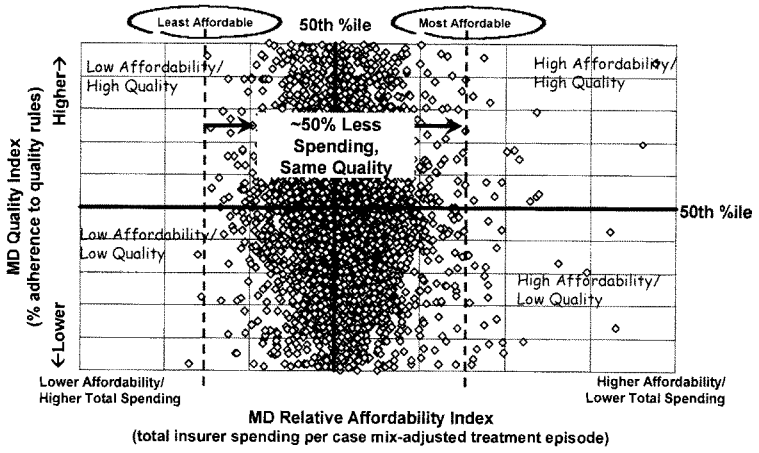
The full power of these measurement tools in America's battle to tame health insurance affordability and poor quality lies not in the one-time opportunity for pioneering employers, unions, or insurers to reduce spending 2-17% by incentivizing enrollees to link to more fuel-efficient, high quality physicians. *Rather, it lies in the motivational power of performance transparency in any industry, including the physician services industry, to propel continuous gains in affordability and quality, once consumers and/or prices begin to favor better, leaner service providers.*

To open this pathway to a higher quality, waste-free American health care system, CMS need not expend additional funds. Under S.1544, requestors of the data would pay Quality Reporting Organizations competitive prices for fulfilling each requested performance report; and the Quality Reporting Organizations would reimburse Medicare for its cost in supplying CMS claims data. Moreover, CMS, other federal agencies and their beneficiaries would reap substantial benefit, since resulting improvements in physician performance would also lift the financial sustainability and quality of care for the Medicare, Medicaid, Tri-Care, and FEHBP programs.

No one has more influence on clinical and financial outcomes than physicians do. Today's American health care market is only beginning to awaken to the error of primarily incentivizing high volumes of high margin services, rather than encouraging physician excellence in quality and "all-in" affordability. Instead of endlessly passing the hot potato of health care spending growth between payers, consumers, and providers, let's unlock the capacity of American physicians to lead continuous innovation in value for their patients in both office and hospital settings.

Attachment A

At Every Level of Quality, MDs with the Most Affordable Practice Patterns Incur Up To 50% Lower Insurer Spending Than Least Affordable MDs (each dot is a Seattle MD)



Adapted from Regence Blue Shield; for Seattle MDs

Attachment B

Proof of Concept by Pioneering Purchasers and Insurers

% Reduction in Per Capita Spending Compared to Similar Local Plans via Composing MD Networks Based on Relative "All-in" Affordability, Rather Than on Lowest Fees; Quality of Care Measures Were Unchanged or Improved

Pitney Bowes, 1995 Connecticut [1]	**17%**
Culinary Union Trust, 2003 Nevada [2]	**7-8%**
PacifiCare, 2005 Multiple States [3]	**6%**
Aetna, 2006 Multiple States [4]	**2-3%**

[1] Appendix II in "Improving the Value of Health Benefit Plans Thro ugh Consumer -Driven Health Care," Mercer Human Resource Consulting, April 25, 2002

[2] Slide 2, Testimony of Peter V. Lee before the House Subcommittee e on Health Promoting Quality and Efficiency of Care for Medicare Beneficiaries, March 15, 2005

[3] e-mail correspondence from Dr. Samuel Ho, PacifiCare, May 3, 2006

[4] e-mail correspondence from Dr. Donald Storey, Aetna, April 26, 200 6

Chairman CONRAD. Thank you, Dr. Milstein. Thank you very much for that very interesting testimony. I know that we are running close to the time that you need to leave.

So I am going, if I could, just ask the other witnesses to withhold for a moment so that I can ask you about the legislation that has been introduced by the ranking member of the Committee, Senator Gregg, and Senator Clinton.

Can you give us a sense, does it include quality measures?

Dr. MILSTEIN. Yes. It essentially enables anyone, any citizen, any organization, to order from a small number of federally qualified analysts of the Medicare claims data base, any report pertaining to quality of care or efficiency of resource use. And so it is essentially an opportunity for any—whether it is Consumers Union or General Motors—to have a full set of performance statistics on physicians, on hospital departments, on any unit of analysis, as long as the only purpose of the request is to generate performance information about the health care system.

Chairman CONRAD. Let me ask, do you see any risk in this proposal? Is there any downside to this?

Dr. MILSTEIN. Yes, I do. I feel that in any industry—at the beginning of performance measurement in any industry we know the additional measures are not going to be exactly right. I would reflect back on the early car crash safety ratings. They were only based on frontal impact. In retrospect we could say gee, it would have been a lot better had we also had side impact, three-quarters impact, and rollover testing.

I think very analogous to that, early uses of insurance claims data bases to generate measures of quality and resource use efficiency are going to be directionally correct but not perfect. And I think that is one of the risks associated with moving forward is the resulting measures, I do believe, will be directionally correct, as verified by those that have begun to use them. But I think they will be imperfect.

At the margin, for example, some hospital departments or some physicians will get a B+ rating when actually they deserved an A-.

Chairman CONRAD. And how is quality included? The thing that I am struggling to understand is if you are getting data from analysts and they have readily available to them cost data, quality data less readily available to them, how do we ensure that somebody who may be a higher cost doctor who also happens to be the best quality doctor, that those two facts do not get lost and we only wind up seeing the high cost?

Dr. MILSTEIN. Will first of all, I think it is a very valid concern and one that, as a physician, I share. I think the good news side of it is that every single purchaser that did have enough claims data density to go forward without access to the Medicare claims data has intuitively sensed that it would be irresponsible and nonviable to try to go forward with an approach to physician or hospital department rating that did not include quality as well as resource use.

Whether one is a steward for a group of employees or a group of union members or members of, for example, a State Government insurance plan, it is simply in this country no longer doable post-

managed-care backlash to proceed forward with any rating system that does not also include quality of care.

Chairman CONRAD. That really is my concern. I withheld cosponsoring the bill because of that concern. I think it has enormous merit and I am very intrigued by your testimony here today. I regret that other business takes you away from us but we certainly understand that.

We will now turn to Mr. Nichols, the Director of Health Policy at the New America Foundation. Welcome, Dr. Nichols, good to have you here.

Thanks so much for your patience. Dr. Collins, as wealthy, thank you for your patience.

STATEMENT OF LEN NICHOLS, PH.D., DIRECTOR, HEALTH POLICY PROGRAM, NEW AMERICA FOUNDATION

Mr. NICHOLS. Thank you, Mr. Chairman, Senator Wyden, and other members of the Committee. I would like to thank for inviting me to testify on health system reform today.

Your invitation asked me to address three specific questions, the first of which is how should the Committee evaluate health care reform proposals? I would offer two criteria for your consideration. First, does the proposal match the scale of our problems? And the second, is the proposal capable of earning bipartisan support?

Now your own charge at the beginning of this hearing, Peter Orszag last week, I have some charts in my written testimony. They all make the point. You all clearly get it. The scale of our problems is very large. So I will not belabor that point.

I will just say to match the scale what I will call a major-league proposal worthy of your time must have three elements. It must cover everyone. It must have some way to reduce cost growth in the long run and increase value. And it must offer a credible financing package that can sustain the system over time. Any proposal without these three elements, in my view, should be labeled minor league and kept at the end of your queue.

If a proposal would not cover everyone, it is not serious for it continues to ignore the cost shift and adverse selection that messes up our insurance markets. If it does not have a credible plan for reducing cost growth, you know what? None of us are going to be able to afford health care in the coming decades. Third, if the proposal does not have a credible financing package, it is not being honest with the American people about the costs and benefits of investing in a new health care system.

You all know we have tried dishonesty before. I will simply observe it did not work. We can do better than that.

On the bipartisanship point, the second criterion should simply be this, it has to be capable of earning bipartisan support. I have heard a lot of that. In fact, I have heard more of that this morning than I have heard in 5 years of testifying up here. This is a very good Committee. I applaud your work.

Bipartisan reform means that each side must recognize the key elements of their own priorities within the solution. For Republicans, in my mind, this means individual choice and market forces. For Democrats it means a solution must work for all of us, including those who are low income or high health risks. And I believe

it is sharing these perspectives that is what brought Senators Wyden and Bennett to cosponsor the Healthy Americans Act. In my judgment, this is the only major-league proposal that has bipartisan support in the 110th Congress at this moment.

The second question you asked was what are some possible options for health care reform? In my view, after many years of looking at this, I will say there are only three credible ways to cover all Americans: single-payer Medicare for all; employer mandates plus individual mandates; or individual mandates alone. I will tell you technically, as a health economist, they all could work. They all have their pluses and minuses. But each approach really does have some weaknesses that are worth addressing.

In my view, the largest weakness of the single-payer approach is that the American people do not seem to me to trust Government enough to let it take over the health system altogether.

On the employer mandate side, I am really sympathetic to Senator Stabenow's problem in Michigan. The fundamental worry I have about an employer mandate is international competitiveness. Again, I have some charts in my written testimony I would be glad to talk about but I think it is fundamentally true if this was not a problem employers would not be dropping coverage like some are. Employers would not be reduced the share of the premium they are paying like many are. And employers would not be reducing the generosity of the coverage they offer like almost all of them are. This is not being shifted. They are bearing some of this cost.

So that leaves me with individual mandates. To my view, they have much to recommend them. First, they are consistent with the personal responsibility vision of conservative reformers. And they also make insurance markets both more efficient and more fair by solving adverse selection problems which liberals like on good days.

The one real fear of individual mandates is precisely the one expressed by Senator Stabenow earlier. How can you make sure these packages are going to be affordable? And I submit to you that is important. That is the most important question. In a sense, I would say this is not really a critique of individual mandates per se but a broader distrust of the whole reform system. And I submit therefore the burden of reassuring proof about commitment to affordability and fairness is in the details of the legislation. And here I would say the Healthy Americans Act does a better job of this than either the State of Massachusetts or Governor Schwarzenegger has done so far in their proposals.

So part of why this is true is because the Healthy Americans Act can redirect a large and regressive tax expenditure money that gives Federal reformers more degrees of freedom than any State has on their own.

The final question the Committee asked, how do we provide quality health insurance to more individuals and families, decrease the number of uninsured, improve health outcomes and contain costs? First, I applaud your ambition. But this is the proverbial key question.

I would offer a two-part overarching answer. The first is simple: buy smarter. It gets to the operational details Senator Whitehouse talked about.

The second though may be more important. Think hard about whom we are buying for and why we are doing it.

I would defer to Arnie and Sara to follow on buying smarter. They are going to talk about that a lot. I will just mention the three elements that have to be there, and I think we all already agree: electronic records, better incentives, and comparative effectiveness information that is widespread. We need them all. We need them tomorrow. And if we start this afternoon, we can have them all in 5 years.

But I want to close by focusing on the last part of my answer to this question. For whom are we buying and why? I submit to you that there are 10,000 technical questions about health reform. We have talked about a lot of them today. You are going to talk about all of them a lot of times after this. But there is one fundamental question and I think it is a moral question that we should ask before we begin to answer any of the technical questions. That is who should be allowed to sit at our health care table of plenty?

This is a question about community. What kind of community do we think we want to nurture and build and maybe rebuild? The older I get, the more gray in my beard, the more convinced I am the best descriptions of community we have are the oldest descriptions we have. I am talking about the Hebrew prophets which, as you know, inspired Jesus and Mohammed as well. A fair reading of our Jewish, Christian, and Muslim scripture says communities have an obligation to feed the hungry, the widow, the orphan, the stranger who would otherwise have starved. Preventable starvation was unacceptable in ancient times, even for the stranger. Because all humans were believed to be made in the image of God and believed to possess the right to participate in the life of the community.

I submit to you health care has become like food, a unique gift capable of restoring and sustaining lives that are stricken with illnesses which could, after all, be any of us anytime because we are all the stranger.

Now the Institute of Medicine has concluded after 3 years of committee meetings, six volumes of published reports, lots of footnotes, 18,000 Americans die every year for lack of health insurance which prevents them from getting the care that rest of us routinely get. These preventable deaths and the human suffering and lost productivity of preventable illness are a dark stain on our Nation. And the fact that most uninsured lack health insurance because of cost, in my view, is tantamount to denying food to the poor, the widow, and the orphan when Moses, Jesus, and Mohammed taught. I do not think they would approve.

At the same time no community was ever told to share food exactly equally, to give all of its food to one person. Stewardship of the collective resources of the community was always part of leadership. Indeed, when you consider another of the Institute of Medicine's findings, that the total social cost of the uninsured, including economic loss of premature death, unnecessarily prolonged illnesses, et cetera, that total social cost of the uninsured is roughly equal to the new public cost of covering the uninsured. Which is why, by the way, the math of Senator Wyden and Bennett works out.

You realize that health reform is at least as much about stewardship as it is about charity.

I would also point out that Leviticus, the source of all of this, the landowner is not told to cook the food and invite the stranger home to dinner. But rather is told to leave the food in the field for the stranger to gather themselves.

Our oldest obligations to each other have always been reciprocal. Each community has the right to define the rules of participation but it must keep the door open to willing passersby. Therefore, requiring people to obtain property subsidized coverage and to take personal responsibility for their own health is perfectly consistent with this interpretation of the timeless moral case. As is expecting the leadership of the community, that would be you, to exercise stewardship over its collective resources, including the health care delivery system.

This shared responsibility extends to making the system more efficient so we can buy health care smarter for all of us.

Thank you very much.

[The prepared statement of Mr. Nichols follows:]

NEW AMERICA
FOUNDATION

Statement of Len M. Nichols*
Director, Health Policy Program
New America Foundation

Heath Care and the Budget: The Healthy Americans Act and Other Options for Reform

before the
Committee on the Budget
United States Senate

June 26, 2007

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Washington, DC 20009

*I am very grateful to my New America colleagues Elizabeth Carpenter, Tom Emswiler, Hannah Graff, Topher Spiro, Meg Barry and Leif Haase for excellent advice and research in support of this statement. I remain responsible for any remaining errors or inconsistencies.

Chairman Conrad, Ranking Member Gregg, other Members of the Committee, thank you for inviting me to testify today on health system reform. My name is Len M. Nichols and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, DC. We also have an active branch office in Sacramento, California. Our program is committed to pursuing policy ideas and conversations that will lead to all Americans having affordable access to a high quality and sustainable health care system. We are involved in this work here in our nation's capital and in various state capitals across the country. I am happy to share ideas for your consideration today and hereafter with you or with committee or personal staff.

I applaud you all for being willing to lead our nation in a serious bi-partisan conversation about reform that is long overdue. With your help, I believe it is possible, this time, for us to fashion an American solution that will both work and engender broad and lasting support.

Your letter of invitation asked me to address three specific questions, which I do in turn below.

How should we evaluate health care reform proposals?

I would encourage you to adopt two criteria: (1) Does the proposal match the scale of our problems? (2) Is the proposal capable of earning bi-partisan support?

Scale

CBO Director Peter Orszag's testimony before you last week[1] ably laid out the macroeconomic and budget stresses, as well as some of what we know about poor health outcomes, that are caused by our health system's inefficiencies. Most of you are not new to these issues, and I know you are well aware of the immensity of the scale of our problems.

I would offer one additional fact to convey a family dimension to the economic imperative for health reform (see slide #2). In 1987, a family insurance policy cost 7.7% of median family income. Today, health insurance claims almost 20% of the median family's income. In my view, this is the single most important reason such a wide range of people across our nation are calling for you and other leaders to help us reform health care. Health care cost growth has exceeded average productivity growth for so long and by so much, that the simple truth is an increasing fraction of our workforce cannot afford health insurance as we know it. This trajectory is unsustainable, whatever the aggregate facts about shares of GDP and budget projections and all the rest. So the scale of our problems is definitely large.

[1] Statement of Peter R. Orszag, Director, Congressional Budget Office, *Health Care and the Budget: Issues and Challenges for Reform*, before the Senate Committee of the Budget (June 21, 2007).

To match this scale, a "major league" proposal worthy of your serious consideration must have three elements: it must cover everyone, it must reduce cost growth in the long run, and it must offer a credible financing package that can sustain the program over time. Any proposal without all three elements, in my view, should be labeled "minor league" and be relegated to the distant rear of proposals vying for your attention.

If a reform proposal would not extend health insurance to all Americans (and legal immigrants), then it is not serious, for it deliberately continues to ignore the cost-shifts and selection problems that plague insurance markets today. These problems perpetuate high costs for some at the expense of others, and keep insurance unaffordable for many. Health insurance is not an end in and of itself, but overwhelming research evidence supports the view that insurance *is* a necessary (but not sufficient) condition for access to timely and efficacious high quality care in our country.[2]

If a reform proposal does not have a credible plan for reducing cost growth and improving clinical value per dollar spent, then very few of us are going to be able to afford health insurance in the coming decades.

If a reform proposal does not have a credible financing package, then it is not being honest with the American people about the costs and benefits of investing in a reformed health system. You all know we've tried dishonesty before. It didn't work and never will. Let's just agree now, at least in this committee, to be honest with each other about how we intend to pay for what we want. My favorite new financing sources include redirecting existing tax subsidy dollars and capturing savings from increased efficiencies, which over time, ought to be close to enough to finance a reformed health system that can serve all Americans well.

Bi-partisanship

The second evaluation question I recommend you ask of reform proposals is this: is the proposal capable of earning bi-partisan support? There is no inherent reason health reform has to be a partisan issue. The cry of a sick child or of an uninsured adult in untreated pain is not a partisan sound. Health reform becomes partisan when it gets used by those who prefer rigid ideology over objective analysis of the essential roles for government or employers. We can keep analysis front and center, if we agree to try.

Bi-partisan reform is the only kind that will be politically sustainable over time. This simple truth is why you must reach across the aisle and fashion compromise. Bi-partisan reform will require that each side realize the key elements of their own values and priorities within the structure of the solution. For Republicans, this means individual

[2] Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington, D.C.: National Academies Press, 2001); Jack Hadley "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *Journal of the American Medical Association* 297(March 2007): 1074-1084.

choice and market forces must be central, and for Democrats it means that the solution must work for *all* of us, including those with low incomes or high health risks.

Bi-partisan reform does not mean unanimity is required, for that would grant veto power to the most extreme views in each caucus. Nor does it mean that support has to be balanced at the outset: only 13 Republicans voted in favor of Medicare in 1965, but I daresay very few would vote to abolish the program today. Today, most Republicans I know want to reform Medicare, not end it, as do most Democrats (as do most policy wonks, in case you are wondering). But bi-partisanship does require that thoughtful leaders on each side of the aisle be involved in shaping the proposal to ensure that the core values of their respective caucuses are actually present in the contours of the solution, whatever the press releases might say.

I believe sharing these perspectives is what brought Senator Wyden (D-OR) and Senator Bennett (R-UT) to agree to co-sponsor S. 334, the Healthy Americans Act. This is the only "major league" proposal in the 110th Congress at this moment, in my view.

What are some possible options for health care reform?

There are only three analytically credible ways to cover all Americans: (1) tax-financed single payer/Medicare for all; (2) employer plus individual mandates to purchase private health insurance; (3) individual mandates alone. Programs that do not require participation will never approach universality, analysts with long histories advising those on either side of the aisle agree.[3]

"Medicare for all" or **single payer** is technically feasible, and could save considerable administrative costs in a "one time" adjustment to standard claims forms and the end of insurer underwriting and risk selection. However, a single payer system would require a generalized level of trust toward elites and governmental decision-making that I for one do not observe throughout the country, despite the well-intentioned efforts of many advocates, and notwithstanding the political popularity of the Medicare program *for the elderly.* The truth is, as Peter Orszag showed us again last week, private and public health care costs have grown at practically the same average rate since 1970. Therefore, our current "single payer" buyer has been no more effective at containing costs over time than the private sector. This may be because Congress will not delegate the authority it would take to run the program as efficiently as advocates imagine it could be, but that is the point.[4] If Congress can not delegate enough authority to run Medicare efficiently, then why would the American people trust the government to run an efficient single payer system for us all?

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[3] Robert Reischauer, Catherine G. McLaughlin, Mark V. Pauly, Len Nichols and Chip Kahn, *Top Ten Myths About the Uninsured*, (February 11, 2004), http://eriu.sph.umich.edu/pdf/bookevent_transcript.pdf, accessed June 25, 2007.

[4] King, Kathleen M. et al. 2002. "Improving Medicare's Governance and Management; Final Report of the Study Panel on Medicare's Governance and Management." *National Academy of Social Insurance*:39-42

In addition, most of the administrative efficiencies of a single payer system could be obtained through a program of mandatory private coverage, which eliminates the profit from avoiding high risk patients. It would seem telling that only one Democratic candidate for president in 2008, Rep. Dennis Kucinich (D-OH), has proposed a single payer system as a campaign plank, despite its appeal among Democratic primary activists. None of the candidates considered most likely to win the nomination and the presidency comes close to embracing single payer as a systemic solution to our complex health care problems.

The employer plus individual mandate solution could also work technically, and many variants of "pay-or-play" proposals (in which the employer pays a fee or payroll tax in lieu of offering insurance to its workers) have surfaced lately.[5] The common goal of employer mandate proposals is to ensure employers do not spend less than x% of payroll on health benefits for their workers, where "x" is chosen for different strategic and tactical purposes. For example, in Governor Schwarzenegger's proposal, the 4% of payroll "in lieu of fee" for non-offering firms with more than 20 workers, was really designed to establish credibility with Democrats in the California legislature, and raise one billion of the 12 billion dollars needed to finance his health reform plan (more about that later). By contrast, the Democratic leadership in that legislature (Senate President Pro Tempore Perata and Assembly Speaker Nunez) have both proposed a 7.5% levy on virtually all firms regardless of size. This seems to be more about shoring up current benefits and putting the full burden of financing coverage expansion on the business community rather than expanding coverage per se. Details will always differ. The overarching fundamental policy question should be, is it wise to increase reliance on employer financing of our health care system in the 21st century economy?

This question is largely motivated by concern about international competitiveness. A typical argument made by CEOs of American companies engaged in international trade is that other countries spend far less on health care than we do, and are less reliant on employer financing than we are. Thus, US firms already face a comparative disadvantage vs. employers in the developed world, due to their higher health care cost burden.[6] Is it smart to add more costs to this disadvantage?

Many economists dismiss this particular worry, citing conventional theory to argue that higher premium payments are "paid for" with reductions in wages. Any new burden on employers will be financed by workers, not firms. There is empirical evidence to support this "full wage-incidence" theory in the long run, on average.[7] However, there is an

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[5] John Edwards, http://johnedwards.com/issues/health-care/health-care-fact-sheet/, accessed June 25, 2007; Barack Obama, http://www.barackobama.com/pdf/HealthPlanFull.pdf, accessed June 25, 2007; An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts Chapter 58.; Governor Arnold Schwarzenegger, http://www.stayhealthycalifornia.com/, accessed June 25, 2007; Governor Edward G. Rendell, http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Rx-for-Pennsylvania-News-Release.pdf, accessed June 25, 2007.

[6] Harold McGraw III, "Business Roundtable Chairman Outlines Strategies for Strengthening America's Competitiveness" (speech to the Detroit Economic Club, May 2, 2007).

[7] Jonathan Gruber, "Health Insurance and the Labor Market," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse (San Diego, CA: Elsevier, Inc., 2000), 1A: 645-706.

important difference of opinion about how long the "short run" is, i.e., how long does it take for "full wage-incidence" to take effect? If the "short run" of less than full wage-incidence lasts long enough, then the CEOs have a point: adding to the employer burden, however well-intentioned, could harm both economic and health system performance.

CBO Director Orszag's testimony of last week acknowledges this issue, on p. 14:

> "Over time, any changes in these [employer premium] contributions, which are substantial, should be reflected in workers' wages or other benefits, *but the speed of that adjustment could vary."* [italics added for emphasis].

My colleague Topher Spiro and I will argue against the simple-minded long run view of full wage-incidence as a guide to policy conclusions in a forthcoming paper.[8] I summarize some of our arguments below.

First, growth in employer premium payments exceeds revenue growth regardless of the actions of employers to reduce premiums and the strength of macroeconomic demand (see slide 3). This puts pressure on employers to reduce wage growth below inflation plus productivity, reduce profits, or reduce investment which will decrease profit in the long run. None of these choices are good for management, even the first, which makes it harder to attract and hold qualified workers. And note, if full incidence takes more than one year, each year adds to the burden, since premium growth continually outstrips revenue and nominal wage increases.

To provide a sense of the magnitude of this problem, see slide 4. This shows employer premium costs as a percent of payroll, over time for all firms, and recently for firms that offer health insurance and for the workers that actually enroll in employer-sponsored health insurance. These are averages that vary by industry. The bottom line is that currently offering firms are already paying between 10% and 20% of payroll for health insurance.

Slide 5 compares the average employer burden as a percent of payroll across a number of trading partners and international competitors. France (which just elected a more pro-business President) and Germany (for whom reduction of business burden was also a recent election issue) are the only two with burdens within 40% of US firms. These and other countries are glad our health care system is so inefficient and that our firms help bear such a share of the costs.

Again, this differential burden would not be an issue – and employer mandates would be "costless" to jobs and the economy – if employers could just shift premium cost increases to workers smoothly and immediately. We infer that they cannot do this from their own behavior. If employers could shift premium increases to workers' wages, firms would

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[8] Len M. Nichols and Topher Spiro, "Employer-Based Health Care: A Competitive Disadvantage in a Global Economy," New America Foundation Health Policy Program Issue Brief, forthcoming, 2007.

not be dropping health insurance offerings altogether, increasing the share that employees pay and reducing the generosity of benefits offered. We note instead that employers have been using all three strategies as assiduously as labor market competition constraints allow. Employer survey data from AHRQ and the Kaiser Family Foundation confirm that employer offer rates, share of premiums paid, and the generosity of benefits have all declined since 2000.[9]

The implications of these trends are clear. A recent analysis of Current Population Survey data confirms that between 2001 and 2005, the percent of the non-elderly population who were covered by employer-sponsored plans declined by 3.8 percentage points. Half of this decline was due to firms dropping coverage, a little over a quarter of the decline was due to lower employee take-up (due to rising premiums) and the rest of the decline was due to reduced eligibility for coverage.[10]

In the face of these trends, and in recognition that young workers today will likely change jobs far more often than the current crop of older workers did,[11] I sincerely doubt the smartest health reform is to place more burdens on business and thereby reduce our already precarious competitiveness in the world economy. In the "best" case of full incidence, a pay-or-play employer mandate is a form of taxation of lower wage workers to finance universal coverage for lower wage workers. This is not likely to leave them much better off, on balance. In the worst case, many low wage workers would lose their jobs to the "pay" requirements, and mid-level workers would also lose jobs as firms would have even more incentive to move middle-class jobs overseas.

An individual mandate strategy has the virtue of avoiding all the downsides of employer mandates and being easily reconciled with the personal responsibility vision of more conservative reformers. Being required to acquire health insurance is just the logical extension of being responsible for one's own health, which not only includes attention to diet and exercise but also seeking care when appropriate and paying a fair share of one's own health costs. Indeed, it was the strong desire to punish "free riders" -- those who could afford health insurance but remained uninsured and shifted the cost of

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[9] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=1&year=-1&tableSeries=1&tableSubSeries=&searchText=&searchMethod=1&Action=Search, accessed June 25, 2007; Kaiser Family Foundation, Employer Health Benefits 2006 Annual Survey, http://www.kff.org/insurance/7527/index.cfm, accessed June 25, 2007; The decline in generosity of benefits is clear from both the percent of workers with deductibles above $500 (Kaiser) and the rise in median out-of-pocket payments as a percent of income. Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Working Paper. Jessica S. Banthin and Didem M. Bernard, "Changes in Median Burdens for Health Care, 1996 to 2003," Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Working Paper, June 2007.

[10] Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005* (December 2006), http://www.kff.org/uninsured/upload/7599.pdf, accessed June 25, 2007.

[11] Meg Kissinger, "The Millennials," *Milwaukee Journal Sentinel*, June 5, 2005, p. 1; David M. Walker, Comptroller General of the United States, "A Look at Our Future: When Baby Boomers Retire," The Frank M. Engle Lecture, The American College, Bryn Mawr, Pennsylvania, September 28, 2005, p. online.

their emergency acute care to the insured and to taxpayers generally -- that motivated Mitt Romney, former governor of Massachusetts and now a leading Republican presidential candidate, to eventually develop a full universal coverage proposal with an individual mandate at its core. Of course, he had considerable help from Democratic legislators along the way, in the first serious bi-partisan reform effort of the 21st century.

Individual purchase mandates also help achieve more traditionally liberal goals of making insurance markets work better, as purchase mandates significantly reduce the likelihood and insurer's fear of adverse selection. While some of the uninsured are very high risk and consequently uninsurable in current markets, many if not most of the uninsured are healthy. Therefore, requirements to cover everyone, especially those who think they do not "need" insurance, will actually *lower* the average risk of the overall risk pool.[12] The reduction in adverse selection risk will enable fairer restrictions on premiums – e.g., modified community rating – to be enforced without reducing coverage among the healthy. Plus, modified community rating and lower average risk means that the underwriting and selective marketing activities that so many insurers engage in now would be rendered largely redundant, and thus would disappear in a reformed marketplace. This should translate into considerable savings off insurer administrative loads that inflate premiums today.

The downside and opposition to individual mandates stem not from disagreement with all these likely positive effects, but rather from an innate skepticism that adequate subsidies for the low income population and a reformed insurance marketplace are likely to be maintained in a reform centered on individual mandates. Reassurance on this point is essential for this strategy to be widely accepted, and by implication, for single payer and employer mandates to be avoided. John Edwards' campaign proposal,[13] the New America plan,[14] the Wyden-Bennett legislation,[15] the Federation of American Hospitals plan,[16] and ERIC, the ERISA Industry Committee's plan,[17] all promise to couple individual mandates and personal responsibility with the shared responsibility of financing adequate subsidies, a reformed marketplace, and stewardship over the efficiency of the health delivery system (more on that below).

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[12]. Mark V. Pauly and Len M. Nichols, "The Nongroup Insurance Market: Short on Facts, Long on Opinions and Policy Disputes" *Health Affairs* (October 2002): web exclusive.

[13] John Edwards, "Reforming Health Care to Make it Affordable, Accountable, and Universal," http://johnedwards.com/news/headlines/20070614-health-care-costs-quality.pdf, accessed June 25, 2007.

[14] Len Nichols, "Mandatory, Affordable Health Insurance" in *Ten Big Ideas for a New America*, http://www.newamerica.net/files/NAF_10big_IdeasComplete.pdf, accessed June 25, 2007.

[15] Senator Ron Wyden, *Healthy Americans Act*, 110th Cong., 1st sess., 2007, S.. 334, http://www.thomas.gov/cgi-bin/query/z?c110:S.334, accessed June 25, 2007; Senator Ron Wyden, *Healthy Americans Act Section by Section*, http://wyden.senate.gov/Healthy_Americans_Act/HAA_Section_by_Section.pdf, accessed June 25, 2007.

[16] Federation of American Hospitals, *Health Coverage Passport: A Proposal to Cover All Americans*, http://www.fah.org/passport/HCP%20PPT%20Designed%202-16-07.pdf, accessed June 25, 2007.

[17] The ERISA Industry Committee, *A New Benefits Plan for Life Security*, May 2007, http://www.eric.org/forms/uploadFiles/b86a00000009.filename.ERIC_New_Benefit_Platform_FL06060.pdf, accessed June 25, 2007.

However, in the one case of an individual mandate approach being put into practice to date, in Massachusetts, political disagreements over what qualifies as "affordable" (in terms of cost sharing requirements) or "adequate" (in terms of subsidies) led to a relaxation of the mandate for about 20% of the uninsured. This, plus the widespread perception that Governor Schwazenegger's proposed individual mandate plan, while laudable for many reasons, is not generous enough for people just above the highest income eligible for subsidies (about $50,000 for a family of four), has led many (including Senator Obama) to be reluctant to embrace an individual mandate as a requirement in a health reform proposal. In my view, these kinds of excessively parsimonious details can be fixed fairly easily (though at the cost of more subsidy dollars in the short run). However, the burden of politically acceptable proof is clearly on reformers to insure that health insurance and health care will be affordable and that markets will be *both* more efficient and more fair. This appears to be necessary for a national "individual mandate only" proposal to be embraced by a majority of Democrats.

Finally, turning to the final question the Committee asked:

How do we provide quality health insurance to more individuals and families, decrease the number of uninsured, improve health outcomes, and contain costs?

This is the proverbial key question. I offer a two-part overarching answer: (1) buy smarter; and (2) think hard about whom we are buying for, and why we are buying it.

Buy Smarter

While coverage and financing issues are important enough to claim most of what I've written so far, the fundamental flaw in our health system is this: we buy health care blindly, stupidly, and without learning fast enough from past mistakes. If we fail to significantly improve the efficiency with which our health system produces health, a majority of working Americans will likely be uninsured by 2020. I expect my co-panelist Arnie Milstein to devote much of his testimony to this topic and for this to figure prominently in the question and answer session, so I will focus on just the highlights of my vision here.

The first key to buying smarter is, we have to know what we are buying. We should be buying health improvement and maintenance or the management of a chronic condition, but instead we buy procedures and products which are rarely linked and traced to specific outcomes over time. Astonishingly, we have no system of tracking the outcomes of our interventions through the millions of encounters that occur every day. This lack of systematic review and accountability – we basically trust physicians to remember what they were taught and to learn from their own practice experiences and whatever they happen to read or learn from colleagues along the way – is why huge variations in medical practice are perpetuated, why we cannot get most to do what others know works, and also why we cannot stop those providers who are doing many things that add no value. We have no system of proving superior methods to local providers' satisfaction in ways they will accept in real time.

Electronic health records are a key first plank in an infrastructure of excellence, for not only will the patient have a record that will be fully portable across providers, but the research which combined record sets will make possible will enable us to turbocharge our production of useful health- and efficiency-enhancing information. While EHRs will eventually help providers provide better care, the reality is that the upfront investment will likely not pay for itself quickly, and therefore some public investment is probably necessary to spread them nationwide in less than 5 years, like we should. The payoff from such an investment could be huge.[18]

The second plank in buying smarter by building an infrastructure of excellence is to revamp our skewed and counterproductive incentives, on both the demand and the supply sides. Basically, we get what we pay for, and what we pay for are services that providers want to perform, whether they add clinical value or not. The secret is not, however, to re-jigger 10,000 prices in 3,000 counties so that we get them "right" once and for all (or until medical knowledge or technology or input prices change again). The secret is to pay for what we want – health – and then monitor our progress toward that end with EHRs while bundling ever-larger sets of services into one payment, which frees clinicians and providers to find the most efficient way to deliver health, given our particular circumstances. Bundled payments are steps away from fee-for-service payment, a clearly flawed system with a bias toward excess care, and towards (though not reaching) capitation, which alienated a lot of clinicians whose practices could not handle the financial risk and also worried patients about incentives to deny care. Again, the EHR is a key to balancing this tension or squaring this circle. EHRs and the benchmarks they will generate will enable patients and their agents (e.g., insurers, health coaches, medical home directors, etc.,) to monitor quality and thus prevent stinting on care. In addition, the absence of a marginal incentive for low value care will prevent providers from pushing to do unnecessary procedures.

The other supply side incentive that it is imperative to fix, not because it will save lots of money but because it is essential to free physicians to focus appropriately on all the other reforms that are necessary, is our malpractice system. An inordinate amount of energy on both sides of malpractice – spurious suits on the one hand, defensive medicine and a culture of hiding honest mistakes instead of sharing and learning from them on the other – makes this an area ripe for reform. I am no malpractice expert, but simple economics suggests that some combination of a no-fault insurance system – which will compensate harmed patients while creating a culture of learning from mistakes – along with strict quality improvement enforcement – or practice termination – are probably elements of a solution.

On the demand side, there is clearly a role for increased cost-sharing, at least among the middle and upper classes, and maybe even for the lower income population as well, as long as cost-sharing requirements are commensurate with income. The principle is to

[18] Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor, "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs," Health Affairs 24 (September/October 2005): 1103-17.

apply the logic of generic drugs – given free or low priced generics, make consumers pay large marginal prices for brand name drugs, unless the brand name works a lot better for the particular patient – to all of medicine. This will require more comparative quality information, which is the third plank in this infrastructure of excellence.

The third plank in buying smarter by building an infrastructure of excellence is to substantially expand the scope of comparative effectiveness research. Unproductive medical practice variation persists partly because we actually know surprisingly little about which diagnostic and treatment regimens have the greatest likelihood of success for specific groups of patients. Consider the FDA drug approval process as an example. Current law and practice requires a pharmaceutical company to show that a new drug is safe and effective, i.e., it does not have high incidence of debilitating side-effects and is more effective than a placebo. With all due respect (and you will read below some of the respect I have for our religious traditions), there is considerable evidence that prayer beats a placebo. If we raised the bar and said in order to be approved for sale a company will have to show the comparative effectiveness of a new drug vs. existing treatments and for specific sub-populations, that would both change the incentives to develop drugs that truly add clinical value and provide far more useful information to clinicians and patients as they make choices. In exchange for the longer time this research would take, we would need to grant longer periods of exclusivity for the successful drug, thus preserving and even enhancing the incentive to invest in compounds that will add significantly to the quality of our lives.

This principle, better comparative effectiveness information prior to widespread use, could be applied across the board to medical devices and to diagnostic and treatment modalities in a systematic research effort that is the long run key to the large dividends in improved efficiency which we need to earn from our delivery system. Information and incentives for providers as well as patients can enable us to buy smarter, but we cannot develop effective incentives until we develop and disseminate more useful information. A recent paper by Gail Wilensky in *Health Affairs* [19]lays out some options in this regard, including making the agency that leads this effort a public-private partnership, that are worthy of consideration, indeed a number of Members of Congress already are, including Senator Clinton, as well as Congressman Allen (D-ME) and Congresswoman Emerson (R-MO).

Finally, in some ways the most important point about health reform:

For Whom Are We Buying Smarter, and Why?

There are 10,000 technical questions about health reform. We have covered lots of them today and you will consider them all again a thousand times before we come to agreement, I think we all know that. But there is one fundamental question, I think it is a moral question, that we should ask before we begin to answer any of the technical questions: Who should be allowed to sit at our health care table of plenty?

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[19] Gail R. Wilensky, "Developing A Center For Comparative Effectiveness Information," *Health Affairs* (November 2006): w572-85.

This is a question about community, what kind of community do we think we live in, what kind of community do we want to live in, what kind of community do you want to nurture and build, maybe rebuild? The older I get the more I am convinced that the best descriptions of community are the oldest descriptions we have. Yes, I'm talking about the Hebrew prophets.

Before you settle your views on health reform, I would encourage you to re-read Leviticus, the 3rd book of the Torah and Old Testament, chapter 23 verse 22, where you will find the concept of "gleaning" rights. Gleaning rights stem from the admonition to landowners to leave some of their harvest in the field "for the poor and the alien." In Deuteronomy (the fifth book) and Isaiah (a later prophet) the description of those who must be assisted is the more familiar, "widow, orphan, and stranger."

Now the widow and orphan are easy to understand. In many ancient societies, only adult males could own land, and thus widows and orphans had no claim to food, and so could quite literally starve to death without some form of gleaning rights. Life expectancy was very short, so one can readily see the inter-family self-interest in each community agreeing to provide for widows and orphans of their own clan, tribe, village, or nation.

But the "stranger?" Here is an important and unique concept, for one didn't have to be Jewish, didn't even have to be local, to have an equal claim to essential food when merely passing through any Israelite community. The stranger, being a wayfarer, was potentially as vulnerable as the local widows and orphans. The common theme of the widow, the orphan, and the stranger, who must be fed, was their vulnerability in the absence of community largesse.

Jesus, 1400 years after Moses, among other things put a human face on and helped make clear the universal nature of the stranger, by teaching and eating with those considered "unclean" in his time, e.g., lepers, prostitutes, tax collectors, etc. Mohammed, 600 years after Jesus, studied theology with Jews in Yathrib (now Medina) and with Christian monks in the Sinai, and his revelation from God we call the Qur'an uses at various times the poor, the needy, the orphan, the beggar, the captive, as well as the alien or wayfarer, to describe the necessary objects of Muslim charity in the name of serving God's will.[20]

So what was the basis of the stranger's claim on scarce food resources? Every human being was believed to have been created in the image of God, and every human being had a right to participate in the life of the community. True participation requires a more vibrant form of life than abject poverty. At the time our monotheistic scriptures were written, food was the only commodity one human being could give another that would guarantee life. We weren't so good at health care then. The prophets were highly focused on preserving the life of the community -- and individuals within it -- against innumerable physical and spiritual threats. As Isaiah is interpreted to have meant, what

[20] More detail on the sources underlying these interpretations can be found in Len M. Nichols, "The Moral Case for Covering Children (And Everyone Else)," *Health Affairs* (March/April 2007): 405-07.

good is mere physical survival if we forget our covenant to live according to God's Just laws?

And Justice clearly compelled the "haves" to make sure the vulnerable did not starve, for such a preventable death was simply unacceptable then. As it is in our time, for the one thing we Americans DO guarantee to all who want is food to eat – through food stamps, food banks, soup kitchens, etc. I submit our unshakeable commitment to avoiding noticeable starvation comes from our unspoken but unbroken allegiance to this biblical requirement of Justice laid down in many traditions so long ago.

You may think this is an odd digression for testimony to a Budget Committee, but I submit that you are the most important committee to have this conversation in the context of health reform. Consider this: health care has become like food in ancient times, a unique gift capable of restoring and sustaining lives stricken with certain illnesses, which could of course be any of us any time. For the Institute of Medicine (IOM), after 3 years of committee meetings and six volumes of published reports of literature syntheses and interpretations, has concluded that 18,000 Americans, children and adults, *die* each year due to lack of health insurance, since the lack of health insurance prevents them from getting the timely and efficacious care the insured routinely get.[21] These preventable deaths – and the human suffering and lost productivity of preventable illness -- are a dark stain on our nation. The fact that most uninsured lack health insurance because of cost is tantamount to us denying food to the poor widow, orphan, and stranger when Moses, Jesus, and Mohammed taught. I do not believe they would approve.

At the same time, no community was ever told to give all its food to one person, nor to share the amount of food equally among all people. Stewardship of the collective resources of the community, for the purposes of nurturing and strengthening the life of the community as a whole, was presumed to be a responsibility of leadership. Indeed, when you consider another of the Institute of Medicine's findings, that the total social cost of the uninsured -- including the economic loss from premature deaths, unnecessarily prolonged illnesses, etc. -- is roughly equal to the net new public costs of covering the uninsured,[22] you realize that health reform is at least as much about stewardship, buying smarter, as it is about charity.

I would also point out that in Leviticus, the landowner is not told to cook the food and invite the alien home to dinner, but is rather told to leave some harvest in the field for the poor to gather for themselves. Our oldest obligations to each other have always been reciprocal. Each community has the right to define the rules of participation, but it must keep the door open to willing passersby. Thus, requiring people to obtain properly subsidized coverage and to take personal responsibility for their own health is perfectly consistent with this interpretation of the timeless moral case. As is expecting the

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[21] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, 2003).

[22] Ibid.

community at large, with proper leadership, to exercise stewardship over its collective resources, including the health care delivery system. Thus shared responsibility extends to making the system more efficient, so we can buy health care smarter, for us all.

Chairman CONRAD. Thank you, Dr. Nichols, for really excellent testimony. I think you have framed the issues in a very clear and compelling way.

Dr. Collins, welcome. Dr. Collins is with the Commonwealth Fund, has a very good reputation and as somebody who is thoughtful on health care issues. Welcome, and please proceed.

STATEMENT OF SARA R. COLLINS, PH.D., ASSISTANT VICE PRESIDENT, PROGRAM ON THE FUTURE OF HEALTH INSURANCE, THE COMMONWEALTH FUND

Ms. COLLINS. Thank you, Mr. Chairman, ranking member Gregg, and members of the Committee, for this invitation to testify on health care reform.

The U.S. health system performs poorly relative to other industrialized Nations on health outcomes, quality, access, efficiency and equity.

In addition, where you live in the United States matters greatly in terms of access to care, the quality of care and the opportunity to lead a healthy life. A major culprit in the inconsistent performance of the Nation's health system is that we fail to provide health insurance to nearly 45 million people and inadequately insure an additional 16 million more. Universal coverage is essential to placing the system on a path to high performance but the way in which a universal coverage system is designed will matter greatly in terms of whether the health system is ultimately able to make sustainable and systematic improvements on key performance measures.

The Commonwealth Fund Commission on a High Performance Health System's National Scorecard on U.S. Health System Performance found the United States ranks 15th out of 19 countries on mortality from conditions that are amenable to health care. That is, deaths that could have been prevented with timely and effective care. The U.S. ranks in last place on infant mortality.

Not having stable adequate coverage limits access to care. Out of five industrialized countries, the U.S. has the highest share of adults reporting that they have cost-related problems accessing health care.

Our health insurance system is complex, inefficient and administratively costly. In 2003 spending on health and insurance administration commanded 7.3 percent of national health spending compared with 5.6 percent in Germany and around 2 percent in France, Finland, and Japan.

There are wide differences across States in access, quality, and cost. The Commission on High Performance Health System's State Scorecard on Health System Performance finds that across States there is nearly a threefold variation in the percent of adults who are uninsured, ranging from a low of 11 percent in Minnesota to a high of 30 percent in taxes. The proportion of uninsured children ranges from 5 percent in Vermont to 20 percent in Texas.

Across States higher rates of insurance are closely associated with better quality of care. States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of Medicare readmissions within 30 days of discharge.

It is critical that the entire population be brought into the health care system in a way that ensures timely access to care across the full length of people's lives. Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time and in the right setting.

Quality and effectiveness measurement will not be meaningful unless measures reflect the experience of a fully and continuously insured population and the work of their providers.

The design of universal coverage will matter in terms of our ability to achieve high performance. Key questions that the public and policymakers might consider in evaluating health reform proposals include whether proposals improve access to care; whether they have the potential to lower cost growth and improve efficiency in the health system; whether they will improve equity; and whether they will have the potential to improve the quality of care on a system-wide basis.

In terms of approaches to universal coverage, many recent proposals, both at the Federal and State levels, would build on the current system by connecting public and private insurance to ensure more coherent and continuous coverage over a person's life span.

A framework for such an approach would create a new group insurance option similar to the Federal Employees Health Benefits Program with income related premium subsidies, expansion of Medicaid and the State Children's Health Insurance Program, and expansions of Medicare. It would include requirements that employers offer coverage or pay into a fund, and requirements that individuals obtain coverage.

An alternate framework might include a more substantial role for Medicare. All uninsured people, people with non-group coverage, and most Medicaid beneficiaries would enroll in Medicare under this framework. Employers could either continue to offer and pay coverage or pay part of their employees' Medicare premiums. Individuals could not opt out of the system. The program would subsidize both premiums and cost-sharing for lower income families.

Some key components of universal health reform proposals that will help move the system to high performance include the following: insurers should be required to compete on providing added value to the health system in greater quality and efficiency rather than on segmenting or excluding poor health risks.

Private insurers and public programs should negotiate with providers to create fair payment rates for health services and pharmaceuticals.

Patient and provider incentives should be aligned to encourage use of all effective services and avoid use of ineffective services.

All patients and providers should be part of an organized care system that is accessible and accountable for patient outcomes in preventive care and care coordination.

The Nation should invest in fully interoperable national health information technology system.

Thank you.

[The prepared statement of Ms. Collins follows:]

UNIVERSAL HEALTH INSURANCE: WHY IT IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM AND WHY DESIGN MATTERS

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Invited Testimony
Committee on the Budget
United States Senate
Hearing on
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The Healthy Americans Act and Other Options for Reform"

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UNIVERSAL HEALTH INSURANCE: WHY IT IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM AND WHY DESIGN MATTERS

Sara R. Collins, Ph.D.

Executive Summary

Thank you, Mr. Chairman, Ranking Member Gregg, and Members of the Committee for this invitation to testify on health care reform. The U.S. health care system performs poorly relative to other industrialized nations and relative to achievable benchmarks for health outcomes, quality, access, efficiency, and equity. In addition, where you live in the United States matters greatly in terms of access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. A major culprit in the inconsistent performance of the nation's health system is that we fail to provide health insurance to nearly 45 million people and inadequately insure an additional 16 million more. Universal coverage is essential to placing the system on a path to high performance. But the way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is ultimately able to make sustainable and systematic improvements in access to care, efficiency and cost control, equity, and quality of care.

The U.S. Health Care System Performs Poorly Compared with Other Countries

- The Commonwealth Fund Commission on a High Performance Health System's *National Scorecard on U.S. Health System Performance* found that out of a possible 100 points based on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries.
- The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care. The U.S. ranks last on infant mortality.
- Universal participation is essential for dramatic improvement in health care outcomes as well as overall performance of the U.S. health system.
- Not having stable, adequate coverage limits access to care. Out of five industrialized countries studied, the U.S. had the highest share of adults reporting that they had cost-related problems accessing needed health care.

- Our health insurance system is complex and inefficient, and it is based on incentives that are not always aligned with improving quality and efficiency. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending, compared with 5.6 percent in Germany and around 2 percent in France, Finland, and Japan. If the U.S. had had a level of administrative spending similar to that of France, Finland, and Japan, it would have saved an estimated $97 billion on health care costs in 2004. Even reducing spending closer to that of countries with mixed public and private insurance systems like Germany and Switzerland would have saved an estimated $32 billion to $46 billion in that year.

There Are Wide Differences Across States in Access, Quality, and Costs

- The Commonwealth Fund Commission on a High Performance Health System released its *State Scorecard on Health System Performance* in June 2007. This report finds that where you live in the U.S. matters for access to care when it is needed, the quality of care, and the opportunity to lead a healthy life.
- Among the states, there is a nearly threefold variation in the percent of adults under age 65 who were uninsured in 2004–2005, ranging from a low of 11 percent in Minnesota to a high of 30 percent in Texas. Although in all states children are more likely than adults to have health insurance—thanks to Medicaid and the State Children's Health Insurance Program (SCHIP)—the proportion of uninsured children ranges from 5 percent in Vermont to 20 percent in Texas.
- Across states, better access to care and higher rates of insurance are closely associated with better quality. States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care.
- States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of Medicare readmissions within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions.

Universal Coverage Is Essential to Achieving a High Performance Health System

- It is critical that the entire population be brought into the health care system in a way that ensures timely access to care across the full length of people's lives.
- Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time in the right setting. Uninsured patients are more likely to receive wasteful and duplicative care because of a lack of care coordination.

- Quality and effectiveness measurement will not be meaningful unless those measures reflect the experience of a fully and continuously insured population and the work of providers who care for them.
- It will be impossible to realize efficiency in the operation of provider institutions and financing arrangements in the presence of billions of dollars in uncompensated care now paid for through pools of federal, state, and local government revenues and a highly uncertain amount of cost-shifting to other payers.

Design Matters: Key Questions to Consider in Evaluating Health Reform Proposals

- The way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is able to make sustainable and systematic improvements in access, efficiency, equity, and quality of care.
- Key questions that the public and policymakers might consider in evaluating health reform proposals:
    - Does the proposal improve access to care?
    - Does the proposal have the potential to lower cost growth and improve efficiency in the health care system?
    - Does the proposal improve equity in the health system?
    - Does the proposal have the potential to improve the quality of care in the health system?

Approaches to Health Care Reform: Key Features for Improving Access, Cost Control, Efficiency, and Quality

- The majority of recent proposals at both the federal and state levels build on the current system by connecting public and private insurance to ensure more coherent and continuous coverage over a person's lifespan.
- A framework for such an approach would create a new group insurance option similar to the Federal Employees Health Benefits Program (FEHBP), with income-related subsidies for the purchase of coverage; expand Medicaid and the State Children's Health Insurance Program (SCHIP) for lower-income families; and expand the Medicare program for older adults. It would require employers to offer coverage or pay into a fund and require individuals to obtain coverage.
- An alternate framework might include a more substantial role for Medicare. All uninsured people, people with private individual coverage, and most Medicaid beneficiaries would enroll in Medicare. Employers would pay 80 percent of their employees' premium, and workers would pay 20 percent of the premium. Employers

could opt out if they elected to provide an actuarially equivalent benefit. Individuals could not opt out. The program would subsidize both premiums and cost-sharing for families living below 500 percent of the federal poverty level.

Key components of health reform proposals to achieve high performance include:

- Insurers should compete on providing added value to the health system in greater quality and efficiency, rather than on segmenting or excluding poor health risks.
- Payers (private insurers and public programs) should negotiate with providers to create coherent policies and fair payment rates for health services and pharmaceutical products.
- Patient and provider incentives should be aligned to encourage use of all effective services, and avoid use of ineffective services, overuse of services, duplication of care, and waste.
- All patients and providers should be part of an organized care system that is accessible and accountable for patient health outcomes, preventive care, and care coordination.
- Information on the cost and quality of care should be transparent and publicly available.
- The health care system should be patient-centered and the health environment should be supportive of living healthy lives.
- The health system should be scientifically grounded.

Ultimately what is needed to move the health care system to high performance is a coherent set of policies with goals and properly aligned incentives that move all participants in the system in the same direction—toward improving access, quality, equity, and efficiency for everyone. It is critical that all adults and children are able to fully participate in a health care system that is well organized and is based on incentives that ensure that everyone receives the right care, at the right time, and in the right setting over their lifespan. It will not be productive in the long run if we focus overly on the impact of reform policies on the federal budget, or on the budgets of major corporations, or even the impact on our families' budgets. Instead, we can only move forward when we keep our eye on the number that really matters: the $2 trillion that we spend as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets and should be the focal point of our collective energies as we develop coherent, consistent, and equitable health care policy.

Thank you.

UNIVERSAL HEALTH INSURANCE: WHY IT IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM AND WHY DESIGN MATTERS

Sara R. Collins, Ph.D.

Thank you, Mr. Chairman, Ranking Member Gregg and Members of the Committee for this invitation to testify on health care reform. The U.S. health care system performs poorly relative to other industrialized nations and relative to achievable benchmarks for health outcomes, quality, access, efficiency, and equity. In addition, where you live in the United States matters greatly in terms of access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. A major culprit in the inconsistent performance of the nation's health system is that we fail to provide health insurance to nearly 45 million people and inadequately insure an additional 16 million more. Universal coverage is essential to placing the system on a path to high performance. But the way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is ultimately able to make sustainable and systematic improvements in access to care, efficiency and cost control, equity, and quality of care.

THE U.S. HEALTH CARE SYSTEM PERFORMS POORLY COMPARED WITH OTHER COUNTRIES

The Commonwealth Fund Commission on a High Performance Health System found that the U.S. health system falls far short of achievable benchmarks for health outcomes, quality, access, efficiency, and equity.[1] The Commission's *National Scorecard on U.S. Health System Performance* found that out of a possible 100 points based mostly on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries. The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care (Figure 1). In fact, 115 people per 100,000 Americans die from illnesses amenable to medical care before age 75, compared with 75 to 84 per 100,000 in the top three countries—France,

[1] C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

Japan, and Spain. The U.S. ranks at the bottom among industrialized countries on healthy life expectancy at birth or at age 60. And out of 23 countries, the U.S. ranked last on infant mortality, with a rate of 7 infant deaths per 1,000 births, more than double the rates of the top three countries—Iceland, Japan and Finland—and well above the median rate for high-income industrialized countries (4.4 per 1,000 births) (Figure 2).

Access to Care

Access to care is a critical hallmark of health system performance, and the single most important factor determining whether people can obtain essential health care is whether they have health insurance coverage.[2] New studies also underscore how important comprehensive health benefits are to ensuring affordability of needed care and protection from medical costs.[3] Even for those with health insurance, high out-of-pocket costs relative to income can undermine access and financial security.

The number of Americans without health insurance is climbing steadily. In 2005, 44.8 million people were uninsured, up from 43.5 million in 2004.[4] People with low and moderate incomes are most at risk of lacking coverage through an employer and the most at risk of being uninsured. The Commonwealth Fund Biennial Health Insurance Surveys found that 53 percent of adults under age 65 who were living in families with incomes of less than $20,000 spent some time uninsured in 2005 (Figure 3).[5] Rates of uninsurance for people in more moderate-income families ($20,000 to $40,000) rose rapidly from 2001 to 2005, climbing from 28 percent to 41 percent. Health insurance premiums, meanwhile, have been increasing at rates three to four times faster than wages, placing tremendous strain on families and employers alike.[6]

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[2] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

[3] J. Hsu, M. Price, J. Huang et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* June 1, 2006 354(22):2349–59; R. Tamblyn, R. Laprise, J. A. Henley et al., "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association,* Jan. 24-31, 2001 285(4):421–29; P. Fronstin and S. R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans* (EBRI/The Commonwealth Fund, Dec. 2006); S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006); K. Davis, M. M. Doty, and A. Ho, *How High Is Too High? Implications of High-Deductible Health Plans* (New York: The Commonwealth Fund, Apr. 2005).

[4] Analysis of the revised March 2005 and 2006 Current Population Survey, Sherry Glied and Bisundev Mahato of Columbia University, for The Commonwealth Fund, May 2007.

[5] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

[6] G. Claxton, J. Gabel, I. Gil et al., "Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest," *Health Affairs* Web Exclusive (26 Sept. 2006):w476–w485.

Universal participation is essential for dramatic improvement in health care outcomes as well as the overall performance of the U.S. health system. The *National Scorecard* tracks the proportion of under-65 adults who are insured all year and enjoy adequate financial protection. Inadequate protection, or being "underinsured," is defined as having out-of-pocket medical expenses that exceed 10 percent of family income, or 5 percent for those whose incomes amount to less than twice the federal poverty level or whose insurance deductibles alone constitute 5 percent or more of income. As of 2003, 16 million adults were underinsured. Including those who were uninsured for any period of time during the year, 61 million adults, or 35 percent of all adults ages 19 to 64, were either uninsured or underinsured (Figure 4).[7]

Quality of Care

Not having stable adequate coverage, much like having no coverage at all, limits access to care. Out of five industrialized countries, the U.S. had the highest share of adults reporting that they had cost-related problems accessing needed health care (Figure 5). Forty percent of U.S. adults and 57 percent of adults with below-average incomes reported in 2004 that they went without care during the year because of the cost—four times higher than in the United Kingdom, a country with universal health insurance coverage and other protective policies.[8] This problem is particularly acute and has long-term implications for uninsured adults with chronic health problems. The *National Scorecard* found that only one-quarter (24%) of uninsured adults with diabetes had received all three recommended services for diabetes in the last year, less than half the rate of privately insured adults with diabetes (54%) (Figure 6). Collins and colleagues found that that nearly 60 percent of non-elderly adults with a chronic health condition who had been uninsured for some time in 2005 did not fill a prescription or skipped a dose of their medication for their condition because of the cost, compared with just 18 percent of those who had coverage all year (Figure 7).[9] The authors also found that more than one-third (35%) of uninsured adults with a chronic condition went to an emergency room or stayed overnight in a hospital for their condition, compared with 16 percent of those who were insured all year.

The U.S. also performs poorly when looking at the proportion of adults and children who receive recommended screening tests and preventive care. Rates are

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[7] C. Schoen , M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

[8] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (Oct. 28, 2004):w4-487–w4-503.

[9] Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

particularly low among those lacking insurance coverage. Just 31 percent of adults who were uninsured all year received recommended screening tests and preventive care appropriate to their age and gender, compared with more than half of adults with coverage all year (Figure 8).[10] Only one-third (35%) of uninsured children received both a medical and dental preventive care visit in the last year, compared with 63 percent of insured children (Figure 9). Similarly, fewer than one-quarter (23%) of uninsured children have a "medical home"—defined as having a regular doctor or nurse from whom they receive comprehensive and coordinated care—compared with more than half (53%) of privately insured children (Figure 10).

Efficiency

Not only does lacking coverage increase the potential for costly care down the road, it also impedes the delivery of efficient care once a person without coverage enters the health care system. People with and without health insurance may see multiple physicians in multiple institutions and face the inherent difficulties of transferring information and medical records among the providers involved.[11] Breakdowns in the coordination of care can lead to inefficient care, such as the duplication of tests when records become lost. Having gaps in health insurance coverage can exacerbate such coordination problems, particularly when individuals have multiple chronic conditions. The U.S. scores poorly on care coordination compared with other countries. Among adults in poor health, the U.S. had the highest rates of test results or records not being available at the time of their appointment in the last two years, and the second-highest rates of receiving a duplicate test (Figures 11, 12).[12] On both measures, people without insurance reported the highest rates of problems.

Insurance Administration

Private health insurance in the U.S. is characterized by complex benefit and cost-sharing designs and high rates of turnover in plan enrollment. Health plans also incur significant marketing and underwriting costs. The U.S. is unique in that a significant percentage of the cost of health insurance goes to non-health activities: an estimated 10 and 40 percent of premiums, depending on the market and state, is consumed by claims

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[10] Schoen, Davis, How, Schoenbaum, "U. S. Health System Scorecard," 2006; Fund Commission, *Why Not the Best?* 2006.

[11] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Zapert, J. Peugh, and K. Davis, "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005):w5-509–w5-525; A. Gauthier, S. C. Schoenbaum, and I. Weinbaum, *Toward a High Performance Health System for the United States* (New York: The Commonwealth Fund, Mar. 2006).

[12] Schoen, Davis, How, Schoenbaum, "U.S. Health System Scorecard," 2006; Fund Commission, *Why Not the Best?* 2006.

administration, underwriting, marketing, profits, and other administrative costs.[13] In fact, costs of insurance administration are the fastest-growing component of national health expenditures. Between 2000 and 2005, net insurance administrative overhead, including both administrative expenses and insurance industry profits and public insurance program costs, rose by 12 percent per year compared with an average of 8.6 percent for overall spending (Figure 13).[14]

Indeed, the U.S. leads all other industrialized countries in the share of national health expenditures it devotes to health care administration. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending. Similar spending in other industrialized countries ranged from 5.6 percent of national health expenditures in Germany to around 2 percent in France, Finland, and Japan (Figure 14).[15] Davis and colleagues estimate that if the U.S. had had a level of administrative spending similar to that of France, Finland, and Japan it would have saved $97 billion on health care costs in 2004.[16] Even reducing spending closer to that of countries with mixed public and private insurance systems, like Germany and Switzerland, would have saved an estimated $32 billion to $46 billion in that year.

THERE ARE WIDE DIFFERENCES ACROSS THE 50 STATES AND DISTRICT OF COLUMBIA IN ACCESS, QUALITY, AND COSTS

Where you live in the U.S. matters: for access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. This was the recent finding of the Commonwealth Fund Commission on a High Performance Health System's *State Scorecard on Health System Performance,* released in June 2007. The following section draws heavily from this report, which was authored by Joel C. Cantor, Dina Belloff, Cathy Schoen, Sabrina K. H. How, and Douglas McCarthy and can be read in full on the Commonwealth Fund Web site, www.commonwealthfund.org.[17]

The *State Scorecard* documents wide, state-by-state variation across key dimensions of health system performance: access, quality, avoidable hospital use and costs, equity, and healthy lives. While no single state performs at the top across all categories, some states far surpass others. States in the Northeast and Upper Midwest

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[13] J. Gabel, K. Dhont, and J. Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund, May 2002).

[14] K. Davis, C. Schoen, S. Guterman, A. Shih, S. C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan. 2007).

[15] Schoen, Davis, How, Schoenbaum, "U.S. Health System Scorecard," 2006; Fund Commission, *Why Not the Best?* 2006.

[16] Davis, Schoen, Guterman et al., *Slowing the Growth,* 2007.

[17] J. C. Cantor, D. Belloff, C. Schoen, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

often rank high in multiple areas (Figure 15). In contrast, states with the lowest rankings tend to be concentrated in the South. The striking variability across states adds up to substantial human and economic costs for the nation. The *State Scorecard* estimates that if all states could do as well as the top states, 90,000 lives could be saved annually, 22 million additional adults and children would have health insurance, and millions of older adults, diabetics and young children would receive essential preventive care. In addition, Medicare could save $22 billion a year if high-cost states reduced their spending to levels of the average states.

Insurance Coverage Differs Dramatically Across States

Across states, the proportion of uninsured adults under age 65 has risen dramatically over the five-year period 1999–2000 to 2004–2005 (Figure 16).[18] The *State Scorecard* finds that the number of states where 23 percent or more of the adult population is uninsured *tripled,* from four to 12.[19] In sharp contrast, children fared much better during the same period (Figure 17). Thanks to federal support of Medicaid and state expansions through the SCHIP program, the percent of children who are uninsured declined in most states. In only three states were more than 16 percent of children uninsured in 2004–2005, compared with 10 states in 1999–2000.

Insurance coverage rates differ sharply across states.[20] If all states achieved the level of coverage in leading states, 17.2 million more adults and 4.4 million more children would have insurance. The number of uninsured across the nation would be halved.

- Among the states, there is a nearly threefold variation in the percent of adults under age 65 who were uninsured in 2004–2005, ranging from a low of 11 percent in Minnesota to a high of 30 percent in Texas (Figure 18).
- Although in all states children are more likely than nonelderly adults to have health insurance, the proportion of uninsured children varies from a low of 5 percent in Vermont to a high of 20 percent in Texas—a rate four times higher.
- Reflecting differences in state coverage policies, trends in coverage for adults and children have diverged sharply over the past five years. In all but 12 states, the uninsured rate for children has declined. In all but six states, the uninsured rate for adults under 65 has *increased.*

[18] Ibid.

[19] These data are the most recent state data currently available. The U.S. Census department recently announced it will be reissuing insurance data and decreasing the national uninsured count by about 1.8 million. The department noted the trends remain up. Adjusted state data and trends are not yet available.

[20] Cantor, Belloff, Schoen et al., *Aiming Higher,* 2007.

- Alabama stands out in the South for its particularly low uninsured rates for children. In fact, along with Vermont, Massachusetts, Hawaii, Iowa, Michigan, and Nebraska, it is one of the seven states with the lowest rates of uninsured children. Alabama's success in covering children, despite being relatively poor and having low levels of private, job-based insurance coverage, reflects its decision early on to expand SCHIP coverage for children in families with incomes up to 200 percent of the poverty level and to pursue aggressive enrollment policies.

Access to Health Care and Quality Are Closely Linked

The *State Scorecard* finds that across states, better access to care and higher rates of insurance are closely associated with better quality (Figure 19).[21] States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care, as well as other quality indicators. Four of the five states with the best access-to-care rankings (Massachusetts, Iowa, Rhode Island, and Maine) are also among the highest on quality of care. States with low-quality rankings tend to have high rates of uninsured residents. Notably, the five top-ranked states overall (Hawaii, Iowa, New Hampshire, Vermont and Maine) all have high rates of insurance coverage, with nearly 90 percent of working-age adults insured. In contrast, in the five lowest-ranked states (Nevada, Arkansas, Texas, Mississippi and Oklahoma), the share of adults insured ranges between 70 and 78 percent.

This cross-state pattern points to the importance of affordable access as a first step to ensure that patients obtain essential care and receive care that is well coordinated and patient-centered.[22] In states where more people are insured, adults and children are more likely to have a medical home and receive recommended preventive and chronic care. Identifying care system practices as well as state policies that promote access to care is essential to improving quality and lowering costs.

In most states, the quality of care varies by income and insurance, with lower income and lack of insurance linked to lower quality.[23] But such gaps are widest in states that perform poorly on indicators of quality and access overall. Gaps are particularly wide in terms of receipt of preventive care (Figure 20). On average across the nation, 78 percent of uninsured and 71 percent of low-income adults age 50 and older did not receive recommended preventive services, compared with 59 percent of insured and 54 percent of higher-income adults. A similar pattern exists among diabetics. On average, 67 percent of low-income diabetics did not receive basic care according to guidelines for their condition.

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[21] Ibid.
[22] Ibid.
[23] Ibid.

The extent to which children have a medical home also depends on their family's income and their insurance status.[24] Top-ranked states on equity generally performed well for all children, including those in low-income families or without health insurance (Figure 21). In most states, variation on many indicators is much greater among uninsured than insured populations. For instance:

- The proportion of insured adults who reported not seeing a doctor because of cost was less than 14 percent in all states. Among the uninsured, the proportion reporting this ranged from a low of about one of four uninsured residents in North Dakota and Hawaii to a high of 52 percent in the five states with the largest gap for this indicator.
- Across the nation, on average only 14 percent of adults with insurance coverage reported not having a usual source of care. Among the uninsured, proportions without a usual source of care ranged from 38 percent in the states with the smallest disparities to 70 percent in the states with the largest disparities.

Higher Quality Does Not Mean Higher Costs

The *State Scorecard* finds that annual costs of care vary widely across states, with no systematic relationship to insurance coverage or ability to pay as measured by median incomes.[25] Moreover, there is no systematic relationship between the cost of care and quality across states. Some states achieve high quality at lower costs.

States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of Medicare readmissions within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions (Figure 22). Reducing the use of expensive hospital care by preventing complications, controlling chronic conditions, and providing effective transitional care following discharge has the potential to improve outcomes and lower costs.

UNIVERSAL COVERAGE IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM

The findings of the *National Scorecard* and *State Scorecard* point strongly to the need for the U.S. to insure all of its residents in order to move effectively to a higher level of overall health system performance. The U.S. consistently ranks well in back of the pack of industrialized nations—all of whom have varying forms of universal health insurance—on key measures of performance, including preventable mortality, life expectancy, and infant mortality.

[24] Ibid.
[25] Ibid.

Similarly, the 10 overall leading states in the *State Scorecard* have the lowest rates of uninsurance among adults and children. Moreover, many have among the most extensive publicly sponsored insurance programs, with income thresholds that support low- and modest-wage workers and their families. For example, only eight states in the country have SCHIP and Medicaid programs that cover children up to 300 percent of poverty, and five of those states rank among the top 10 states overall in the *Scorecard.*

In addition, two states in the top 10 overall leaders, Hawaii and Maine, have attempted to extend health insurance to most of their residents. Hawaii, which ranks first in the *State Scorecard,* mandated in 1974 that employers—with a few exceptions, such as seasonal employers and government services—provide insurance to all employees working more than 20 hours a week.[26] Maine's Governor John Baldacci signed the Dirigo Health Reform Act (PL 469) into law in June 2003. Dirigo aims to make quality, affordable health care available to every Maine citizen within five years and to initiate new processes for containing costs and improving health care quality.

It will be very difficult for the U.S. to gain control of health care cost inflation associated with chronic illness through the timely use of preventive care and chronic disease management when millions of families lack the financial means to regularly access these services before their conditions become serious and expensive. It is critical that the entire population be brought into the health care system in a way that ensures access to care across the full length of people's lives.

Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time in the right setting. Uninsured patients are more likely to receive wasteful and duplicative care because of a lack of care coordination. Meaningful medical homes—not just places to obtain primary care, but ones that are able to ensure that patients get the prescription drug therapy, follow-up tests, and specialized care that they need—will never be achievable unless families have insurance coverage to provide them with equitable access to the full range of health care that will be required over the course of their lives.

Quality and effectiveness measurement will not be meaningful unless those measures reflect the experience of a fully and continuously insured population and the work of providers who care for them.

It will be impossible to realize efficiency in the operation of provider institutions and financing arrangements in the presence of billions of dollars in uncompensated care now paid for through pools of federal, state, and local government revenues and a highly uncertain amount of cost-shifting to other payers.

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[26] K. Davis, *Spreading State Success* (New York: The Commonwealth Fund, June 2007).

DESIGN MATTERS: KEY QUESTIONS TO CONSIDER IN EVALUATING HEALTH REFORM PROPOSALS

Expanding health insurance coverage to people who now lack it is a necessary but not a sufficient condition for achieving high performance. The way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is able to make sustainable and systematic improvements on the dimensions measured in the *National Scorecard* and *State Scorecard*: access to care, efficiency and cost control, equity, and quality of care. With these goals in mind, the following are some key questions that the public and policymakers might consider in evaluating health reform proposals:

- Does the proposal improve access to care?
    - How many people would become newly insured under the proposal?
    - Does the proposal improve coverage for people who currently have inadequate insurance, with high costs or limited benefits?
    - Does the proposal make enrollment easy and seamless so that it is easy to get enrolled and stay enrolled?
- Does the proposal have the potential to lower cost growth and improve efficiency in the health care system?
    - Does the proposal have the potential to achieve savings in national health spending?
    - Does the proposal pool health care risks broadly?
    - Are specific provisions aimed at slowing cost growth?
- Does the proposal improve equity in the health system?
    - Does the proposal improve equity in access to comprehensive health care services?
    - How does the proposal affect family health care spending across the income spectrum?
- Does the proposal improve the quality of care in the health system?
    - Is the insurance system oriented to towards improving health care quality?
    - Are there specific provisions aimed at improving quality and efficiency?

APPROACHES TO HEALTH CARE REFORM: KEY FEATURES FOR IMPROVING ACCESS, COST CONTROL, EFFICIENCY, AND QUALITY

Current proposals to expand health insurance range in scope from targeted efforts that would cover a defined group of people, such as children, older adults, people with work-ending disabilities, and small businesses, to those that aim to expand coverage options for everyone. Proposals targeted to defined groups of people would have far less impact on the nation's uninsured problem than would more universal coverage proposals. Beyond their potential ability to significantly reduce uninsurance in the targeted population or organizational group, incremental reforms should be critically evaluated in terms of whether they are a component of a long-range plan to reach universal coverage. Do these proposals provide a sound and efficient insurance foundation with a defined road map for achieving affordable, comprehensive coverage? Do they cover the most at-risk populations first?

Current proposals that aim to expand coverage to everyone range from those that are built primarily on public insurance programs like Medicare to those that would rely on private insurance. The majority of recent proposals at both the federal and state levels envision a mixed private and public insurance system that builds on and expands existing public insurance programs and the employer system, and offers new options for people who lack access to either form of coverage.[27] Such new options include merged individual and small-group markets as in Massachusetts's Commonwealth Care Connector, the Federal Employees Health Benefits Program (FEHBP), a public insurance plan such as that offered through Medicare, or new incentives to purchase coverage in the existing individual market.

Framework for a Mixed Private–Public Approach. An example of a framework for a mixed private–public approach was laid out by Karen Davis and Cathy Schoen in the journal *Health Affairs* in 2003.[28] A modified version of this framework builds on the existing system and includes an employer mandate, an individual mandate, and a new group insurance option that would operate like FEHBP. Employers would be required to either offer a benefit plan meeting minimum standards or contribute 5 percent of payroll to a fund that would cover their employees under the new group option.

The framework would also expand SCHIP to include all children, parents, and adults up to 150 percent of poverty. In addition, to reduce adverse selection in the new group option, a new Part E would be added to Medicare to expand coverage to those age 60 and over who lack access to employer coverage and to dependents of current

[27] J. L. Lambrew and J. Gruber, "Money and Mandates: Relative Effects of Key Policy Levers in Expanding Health Insurance Coverage to All Americans," *Inquiry*, Winter 2006/2007 43(4):333–44.

[28] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003):w3-199–w3-211.

beneficiaries; the two-year waiting period before the disabled can join Medicare would be eliminated. Medicare Part E, which would consolidate Medicare Parts A, B, D, and supplemental coverage into one benefit, would also be available through the new group option.

The new group option would be open to firms with fewer than 100 employees and individuals without access to employer-based coverage or Medicare. They could choose to enroll in Medicare Part E or in other private integrated plan options offered through the new option, like those of Kaiser Permanente. Medicare Part E would be the only fee-for-service option available. All tax filers would be required to show proof of insurance coverage at the time of filing. Those whose employers do not offer coverage and whose incomes fall above 150 percent of poverty would be eligible for tax credits to cover premiums in the new group option in excess of 5 percent of income, or 10 percent for higher-income families.

Other features include a requirement that companies provide coverage to dependents up to age 26 under their parent's policies, and that companies extend coverage to employees for up to two months after a loss of a job, with the federal government subsidizing 70 percent of the premium.

Framework for an expanded Medicare. A variation on the mixed private–public model might include a more substantial role for Medicare. In such a framework, all uninsured and people with private individual coverage would be enrolled in Medicare. Medicaid beneficiaries, except for those also covered under Medicare (i.e., dual-eligibles), would also be enrolled in program. Employers electing to provide an actuarially equivalent benefit could opt out of the system. People in covered groups would not have the option of declining coverage under the program, except in cases where their employer has exercised its option to provide coverage separately.

Premiums would be community–rated, so that the premium would be uniform for all participants and would vary only with family composition. There would be no adjustment for risk characteristics. Community-rated premiums would be based upon expected costs for newly enrolled people, assuming that providers would be reimbursed at Medicare payment levels.[29] Employers would pay an amount equal to 80 percent of premium, prorated for part-time workers, and workers would pay 20 percent of the premium. Non-workers would pay 100 percent of the premium. The program would subsidize both premiums and cost-sharing for families living below 500 percent of the federal poverty level. Savings to states from the elimination of Medicaid for the covered population would be transferred to the program (i.e., state maintenance of effort).

[29] Medicare payment levels are typically above Medicaid payment levels but less than what private payers pay for comparable services.

Medicare would remain distinct in the system. The benefits package would cover the services now covered under the Medicare program, plus certain services not now covered under Medicare. Current Medicare recipients would be covered for the same services the program now covers but also would be eligible for the cost-sharing and out-of-pocket spending subsidies under the newly expanded program.

The inclusion or omission of key features in both general approaches has significant implications for the number of people covered, the cost to federal and state governments and the overall health system, equity in access and financing, and improvements in efficiency and quality. These are discussed below.

Access to Care

How many people would the proposal cover? Proposals that aim to cover nearly everyone vary in terms of their effectiveness, which previously uninsured people would gain coverage, and what their source of coverage would be. Jeanne Lambrew and Jonathan Gruber argue that the most important features in the mixed private–public approaches in terms of impact on coverage are: 1) whether employers are required to offer and contribute to coverage; 2) whether individuals are required to obtain coverage; and 3) the structure and generosity of public subsidies, including expansions of public programs.[30] Other key features that matter, in terms of impact on people covered, include the degree of risk pooling, and whether there is an autoenrollment mechanism.

In simulation exercises of several variations on mixed private–public approaches, Lambrew and Gruber found that the inclusion of an individual mandate is critical to achieving universal coverage. An employer mandate alone, even with generous subsidies, falls short of universal coverage, since it fails to reach those with weak connections to the labor force and those for whom the subsidies are not sufficient incentive to enroll. Employer mandates that exclude small firms would cover even fewer uninsured people.[31]

By themselves, subsidies provided to individuals and small firms to help them voluntarily buy-in to a new group option will, in the absence of an employer or individual mandate, fall far short of universal coverage. Moreover, this may, ironically, contribute to people with employer-based coverage becoming uninsured. Lambrew and Gruber find that a proposal that combined a new group option, Medicaid expansion, and generous subsidies to firms and individuals to buy-in to the new option would cover only about 20 percent of the uninsured. This is partly because some small firms with lower-wage workers might drop coverage if they knew their employees had a new option. In addition,

[30] Lambrew and Gruber, "Money and Mandates," 2007.

[31] S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part 1, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

the voluntary nature of individual enrollment would result in large numbers of people continuing to go without coverage.

Another important feature is the structure of the subsidy itself, and whether it would keep pace with inflation over time in medical costs. Subsidies that cap premiums and out-of-pocket spending as a share of income would maintain their value over time. Some other approaches, such as a fixed tax deduction for those who enroll in employer coverage or individual coverage, would necessarily have to be structured so as to maintain their value in the face of rising costs and premiums. For example, income tax deductions that rise less slowly than premiums would have the potential to cover more uninsured people in the first years of the proposal than in future years, when premiums are more likely to exceed the cap and thus be more expensive to taxpayers.

In terms of where people would gain coverage under a mixed private–public approach with employer and individual mandates, most people would maintain their current source of coverage either through their employers or public programs.[32] There would be a large shift to the new group option from the current individual market, an increase in public program coverage, and an increase in employer coverage as a result of the employer and individual mandates.[33]

An expanded Medicare approach like that described above would likely cover everyone. Individuals could not opt out. Prior analyses of such an approach also finds that most employers would not elect to opt out, since it is unlikely that firms could negotiate premiums with rates more favorable to what the government could negotiate.[34] Thus, it is anticipated that most people would have coverage through Medicare, even with the employer opt-out.

Do the proposals improve coverage for people who currently have inadequate coverage, entailing high costs or limited benefits? Proposals that set a floor on acceptable levels of health benefits would improve coverage for millions of people who are currently underinsured and provide comprehensive access to care for people who become newly insured. Many recent proposals have required that that qualifying health plans in new group options would have to be equivalent in value to the Blue Cross/Blue Shield Standard Plan offered to federal employees and members of Congress under FEHBP. In addition, many proposals, including the mixed private–public approach and the Medicare expansion described above, would also cap out-of-pocket costs as a share of income and/or subsidize premiums.

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[32] Davis and Schoen, "Creating Consensus," 2003.
[33] Lambrew and Gruber, "Money and Mandates," 2007.
[34] Collins, Davis, and Kriss, *Congressional Health Care Bills,* 2007.

Some proposals, by expanding access to Medicaid and SCHIP, would improve existing benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults with low to moderate incomes. In the case of both the mixed private–public framework and the expanded Medicare approach, requiring a comprehensive set of benefits and lower cost-sharing in the new program would improve coverage for existing Medicare beneficiaries who face substantial cost-sharing. In contrast, recent proposals that provide incentives for coverage in the private individual insurance market would move some people into plans with more limited benefits or higher deductibles.

Does the proposal make enrollment easy and seamless so that it is easy to get enrolled and stay enrolled? Proposals that would enroll people automatically through the tax system or at birth, such as the mixed private–public approach and the expanded Medicare framework described above, are the most likely to ensure that people become enrolled and remain enrolled. The fact that most people would be covered under one system under the expanded Medicare approach would also help ensure that people remain enrolled, regardless of changes in income, age, health status, or employment status.

More incremental proposals targeted to certain groups of people or income groups face the inherent challenge of enrolling all those who are eligible. This has plagued both Medicaid and SCHIP, resulting in substantial churning when people are dropped if they fail to re-enroll in six or 12 months, depending on the state they live in, as well as millions of adults and children being eligible but not enrolled. Prior analyses have found that adding provisions to increase enrollment and retention in targeted programs do increase enrollment, but that many adults and children eligible for the programs would remain uninsured.[35] This reveals the limited ability of targeted expansions to cover all of those eligible when eligibility is determined by income, in the absence of a more comprehensive national system of coverage, which would automatically enroll people into the coverage for which they are eligible.

Efficiency

Does the proposal have the potential to achieve overall system savings?

The estimated savings to the overall health system from insuring everyone have the potential to be substantial, relative to incremental approaches. Primarily, these reflect the significant potential savings in the cost of insurance administration, particularly in the case of the expanded Medicare framework, but also in the mixed private–public approaches where group coverage replaces the non-group insurance market. The current

[35] Ibid.

system is highly fragmented and complex, with people receiving coverage through multiple, competing insurance carriers. Covering everyone through Medicare would substantially reduce this complexity. But replacing the individual market with group forms of coverage could also lead to substantial savings. As a share of premiums, insurance administrative costs range from 2 percent under Medicare, 10 percent for employer group coverage, and 25 to 40 percent for coverage purchased in the individual insurance market.[36]

Do proposals pool health care risks broadly? How a proposal is structured and how broadly risks are pooled has a fundamental impact on costs. Recent proposals that would provide an equivalent capped income tax deduction for insurance gained through employers or through the individual market would have the effect of moving more people into the individual market. Other proposals would also encourage non-employer coverage in similar ways, but would create new group options and impose restrictions on individual underwriting. Prior estimates have shown the differential impact on the costs of insurance administration to be substantial; proposals that increase coverage through the individual market have the potential to increase administrative costs, while those that provide group options have the potential to significantly lower overall administrative costs.[37]

Incremental approaches that attempt to address the ongoing affordability crisis plaguing small companies that buy coverage through the small group market by regulating or deregulating the market are significantly challenged by the perverse effects of adverse selection.[38] Proposals that would allow groups of companies to bypass state insurance regulations, such as community rating, are estimated to make small group coverage more affordable for companies with a young and healthy workforce, but they also significantly increase premiums for less healthy consumers or companies with older workers. But proposals that establish pools for small businesses with premium protections, federal reinsurance, and tax credits can have the unintended effect of attracting companies with less healthy and older workforces while companies with healthier workforces look elsewhere. In addition, it has proven very difficult to attract large numbers of small employers into such pools even with generous subsidies, in the absence of mandates.[39] It is important that proposals attempt to broadly pool people to avoid the unhealthy dynamic in the small and non-group market that occurs when groups of people can be divided according to age or health risk.

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[36] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003).

[37] Collins, Davis, and Kriss, *Congressional Health Care Bills,* 2007.

[38] Ibid.; unpublished analyses by the Lewin Group.

[39] Lambrew and Gruber, "Money and Mandates," 2007.

Broad risk pooling is also crucial on equity grounds. The proposals that attempt to cover people through existing small or non-group markets ultimately confront the central dynamic governing those markets—the powerful incentive on the part of carriers to protect against health risk. Proposals that would increase incentives for people to gain coverage through the individual insurance market need to address the significant variation in premiums and in the value of benefits that characterize that market. The value of tax credits or tax deductions would likely vary for people who live in different parts of the country and who are of different ages, health status, and gender—not to mention people with severe health problems for whom no insurer will write a policy. In general, proposals that would be built on existing and new group insurance options would avoid these problems, particularly with the addition of an individual mandate. The private small group–non-group insurance connectors established under some proposals, and implemented in Massachusetts, might, without proper safeguards, be more at risk for adverse selection and premium escalation. Protections for these private purchasing mechanisms would include mandatory participation, community rating for the full state market as well as for the insurance connectors, and adequate federal reinsurance.

Are there specific provisions aimed at slowing cost growth? Given the rapid rise of health care costs and its growing importance in the federal budget, proposals to expand health insurance should include features directed towards leveling cost growth.[40] Proposals might include features that would be directed towards improving efficiency in insurance administration and payment, such as requirements regarding the share of premiums devoted to medical care, reducing Medicare Advantage payments, establishing public–private payer purchasing collaborative to negotiate lower pharmaceutical prices, reduce prices for overused services, and have all payers adopt Medicare DRG payment rates. Other possibilities for cost control might include provider payment incentives directed towards reducing variation in costs, such as paying for episodes of care and identifying and reducing cost growth in high-cost regions of the country.

Equity and Affordability

How do the bills affect family health care spending across the income spectrum? The way in which new premium subsidies, tax credits, or tax deductions for the purchase of health insurance are designed has significant implications for how costs or savings accrue across households. Both the private–public mixed approach and expanded Medicare approach described above have significant premium and cost

[40] P. Orszag, *Health Care and the Federal Budget: Issues and Challenges for Reform*, Invited Testimony, U.S. Senate Budget Committee, Hearing on "Health Care and the Budget: Issues and Challenges for Reform," June 21, 2007.

protections for consumers such that lower-income families pay less than do higher-income families. Cost savings to households also arise from people becoming insured, as well as from the new protection from out-of-pocket costs and premiums that benefit currently insured families who have high out-of-pocket costs and premiums relative to their incomes.

Recent proposals that would provide a new standard income tax deduction for private insurance differ considerably in how progressively the deduction is structured and whether there are additional premium subsidies for lower-income families. Proposals that would extend a standard income tax deduction that does not vary by income and that does not include additional premium support will be most valuable to high-income families.[41]

Do the proposals improve equity in access to health care? Proposals that aim to achieve near-universal coverage with comprehensive benefits and cost protections for families with low and moderate incomes will go the farthest in providing equal financial access to the health care system. More targeted proposals, such as proposals to expand coverage for children and lower-income families, would make small but necessary improvements in providing equal access to the health system for millions of children and adults who face financial barriers to care.

Quality

Is the insurance system oriented towards improving health care quality? A significant barrier to improving the quality of health care nationally is the large number of people who lack meaningful health insurance coverage and are therefore largely outside the system. Those proposals that would cover the most people would help ensure that the population as a whole has access to preventive care and timely essential medical care across the lifespan.

But the ways in which people are insured, the systems that evolve to achieve near-universal coverage, and the role of insurance carriers will be important determinants of whether significant and systematic improvements in quality can be achieved across the country. More centrally organized proposals would enable the nation to develop and utilize common quality metrics, gather data on the health care outcomes of the full population, and evaluate and improve the performance of providers based on a large pool of patients that is not fragmented by insurance type, as is the case today. They also would enable the creation of uniform provider payment systems that reward high-quality care, standardization in health information technology, and the creation of universal processes to improve safety systematically across health care institutions.

[41] Collins, Davis, and Kriss, *Congressional Health Care Bills,* 2007.

Are there specific provisions aimed at improving quality and efficiency in the health system? Proposals to expand health insurance should also be evaluated on the basis of their inclusion of specific measures to improve quality. Proposals that are designed to achieve universal health insurance coverage should be pursued simultaneously with health system reforms that improve quality and efficiency. Universal coverage should not be held hostage until a more efficient health system is achieved, but coverage should also not be expanded without the difficult work of ensuring that the health system is accessible, reliable, and consistently high-quality, and yields commensurate value for the resources invested. Key components of health reform proposals to achieve high performance include:

- Insurers should compete on providing added value to the health system in greater quality and efficiency, rather than on segmenting or excluding poor health risks.
- Payers (private insurers and public programs) should collaborate to negotiate with providers coherent policies and fair payment for health services and pharmaceutical products.
- Patient and provider incentives should be aligned to encourage use of all effective services, and avoid use of ineffective services or overutilization, duplication, and waste.
- All patients and providers should be part of an organized care system that is accessible and accountable for patient health outcomes, preventive care, and care coordination.
- Information on the cost and quality of care should be transparent and publicly available.
- The health care system should be patient-centered and the health environment should be supportive of leading healthy lives.
- The health system should be scientifically grounded.

Ultimately, what is needed to move the health care system to high performance is a coherent set of policies with goals and properly aligned incentives that move all participants in the system in the same direction—toward improving access, quality, equity, and efficiency for everyone. It is critical that all adults and children fully participate in a health care system that is well organized and is based on incentives that ensure that everyone receives the right care, at the right time, and in the right setting over their lifespan. It will not be productive in the long run if we focus overly on the impact of

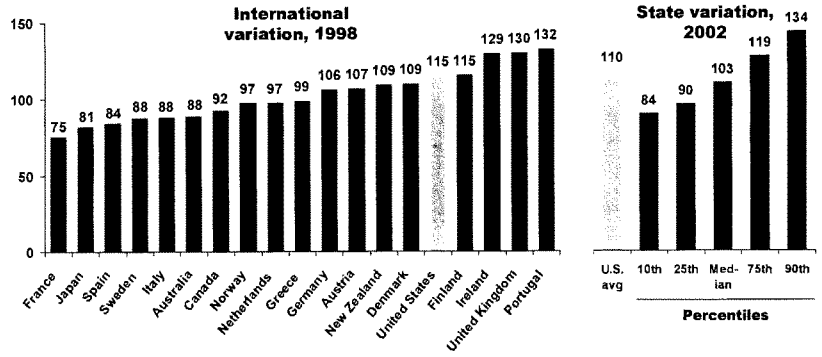
reform policies on the federal budget, or on the budgets of major corporations, or even the impact on our families' budgets. Instead, we can only move forward when we keep our eye on the number that really matters—the $2 trillion that we spend as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets and should be the focal point of our collective energies as we develop coherent, consistent, and equitable health care policy.

Thank you.

Figure 1. Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

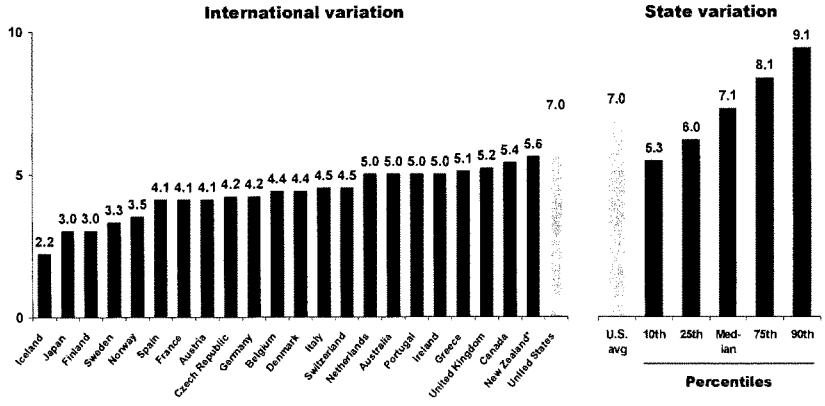
Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003);
State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

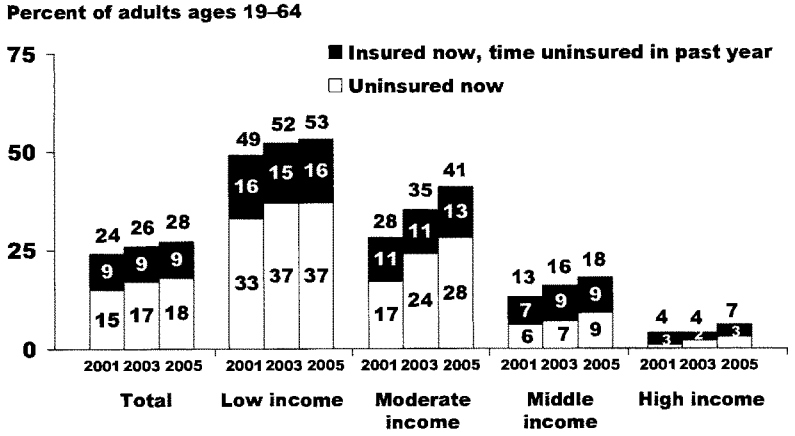
Figure 2. Infant Mortality Rate, 2002

Infant deaths per 1,000 live births



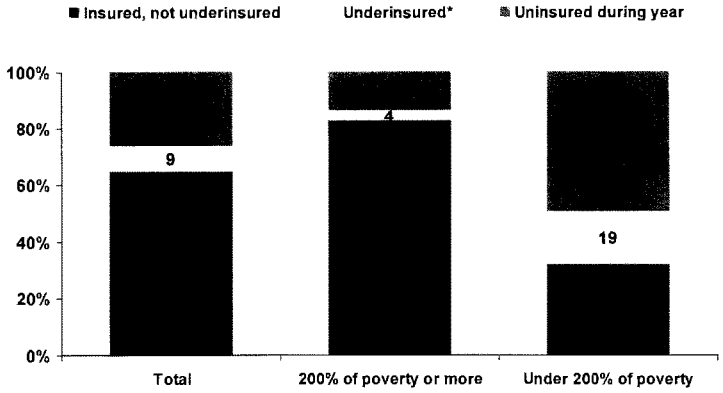
* 2001.
Data: International estimates—OECD Health Data 2005;
State estimates—National Vital Statistics System, Linked Birth and Infant Death Data (AHRQ 2005a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 3. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005



Note: Income refers to annual income. In 2001 and 2003, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, April 2006.

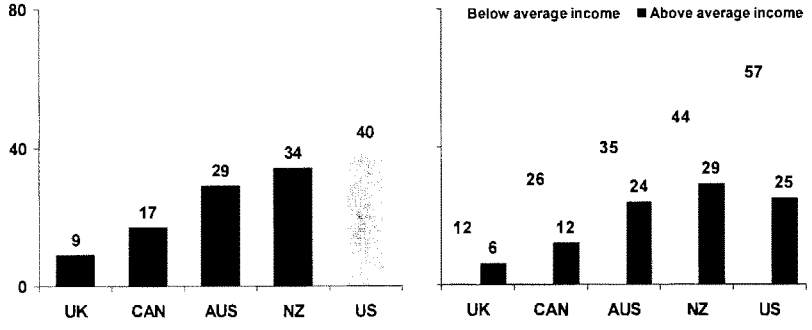
Figure 4. Adults Ages 19–64 Who Are Uninsured and Underinsured, by Poverty Status, 2003



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: 2003 Commonwealth Fund Biennial Health Insurance Survey (Schoen et al. 2005b).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 5. Access Problems Because of Costs in Five Countries, Total and by Income, 2004

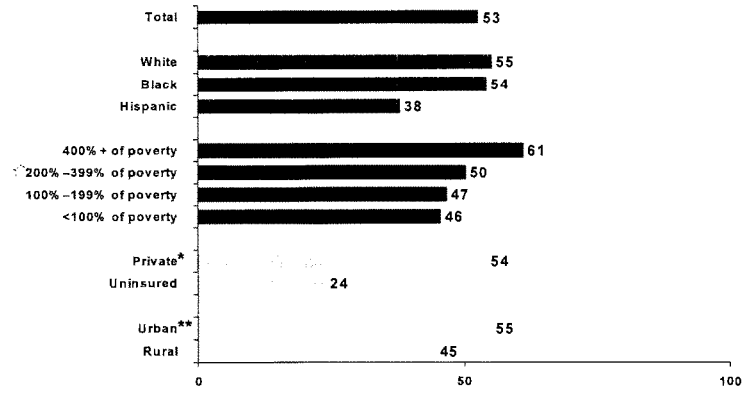
Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.
Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 6. Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity, Family Income, Insurance, and Residence, 2002

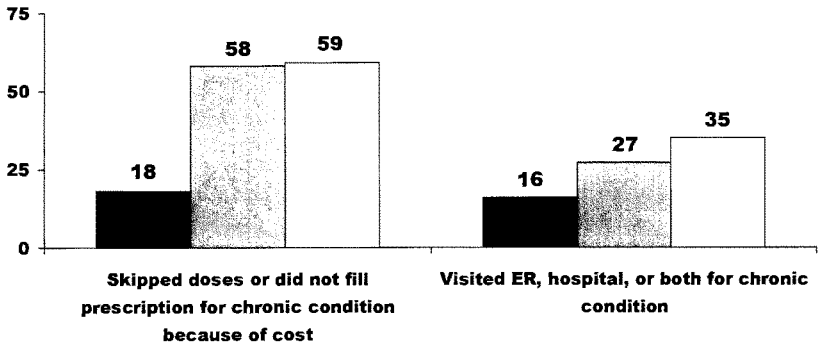
Percent of diabetics (ages 18+) who received HbA1c test, retinal exam, and foot exam in past year



* Insurance for people ages 18–64.
** Urban refers to metropolitan area ≥1 million inhabitants; Rural refers to noncore area <10,000 inhabitants.
Data: 2002 Medical Expenditure Panel Survey (AHRQ 2005a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 7. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

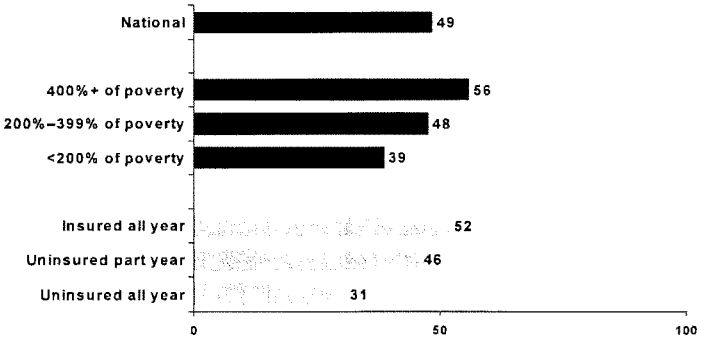
Percent of adults ages 19–64 with at least one chronic condition*



*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).

Figure 8. Receipt of Recommended Screening and Preventive Care for Adults, by Family Income and Insurance Status, 2002

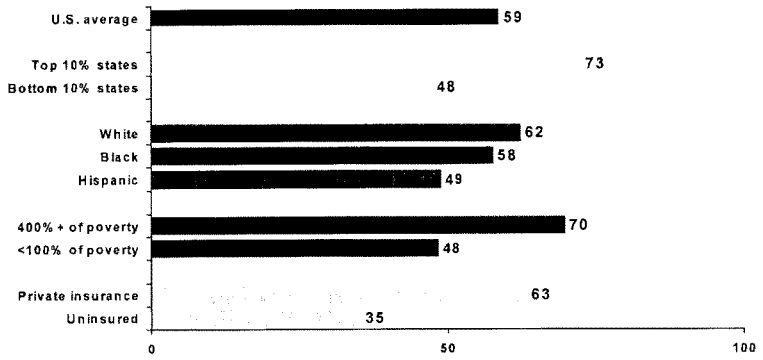
Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot.
Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 9. Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

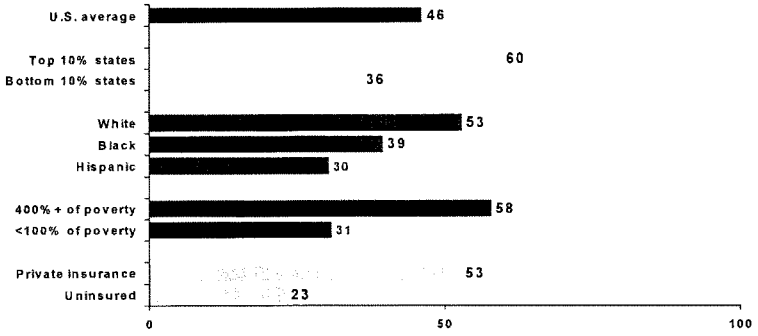
Percent of children (ages <18) received BOTH a medical and dental preventive care visit in past year



Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at http://www.nschdata.org).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 10. Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

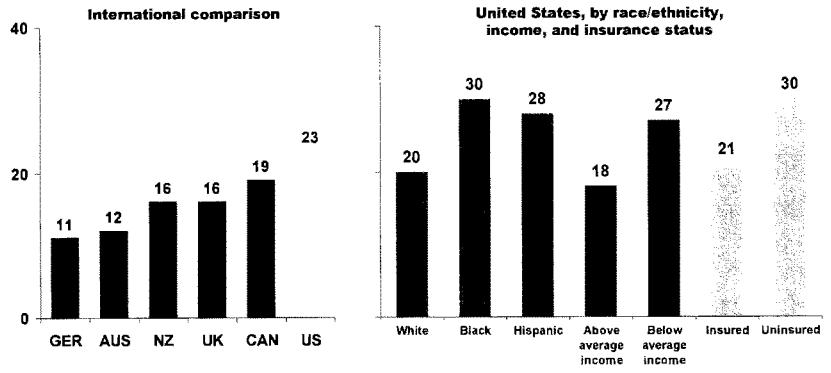
Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*



* Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child's specialty care visits.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at http://www.nschdata.org).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 11. Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2005

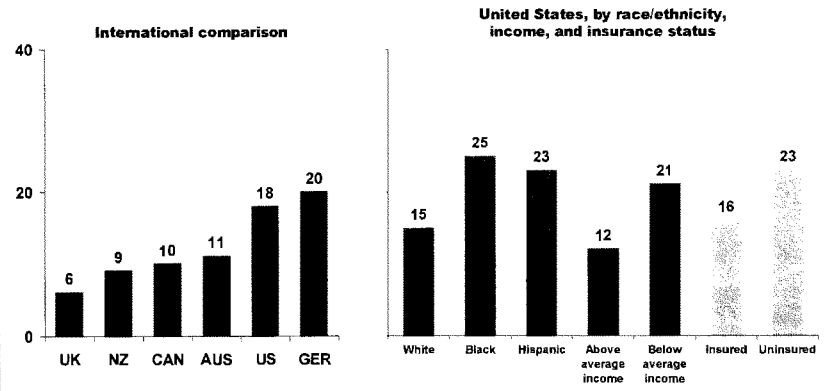
Percent reporting test results/records not available at time of appointment in past two years



GER=Germany; AUS=Australia; NZ=New Zealand; UK=United Kingdom; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

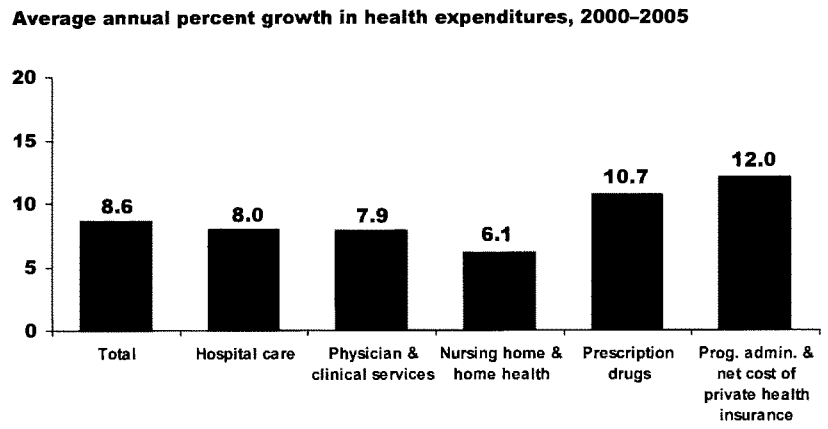
Figure 12. Duplicate Medical Tests, Among Sicker Adults, 2005

Percent reporting that doctor ordered test that had already been done in past two years



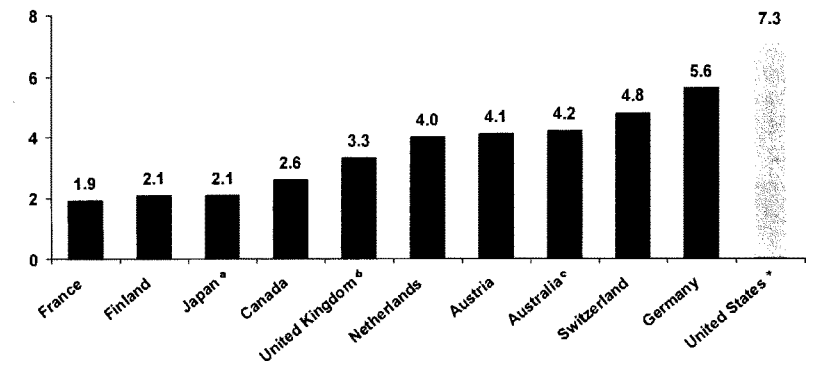
UK=United Kingdom; NZ=New Zealand; CAN=Canada; AUS=Australia; US=United States; GER=Germany.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 13. Health Expenditure Growth 2000–2005 for Selected Categories of Expenditures



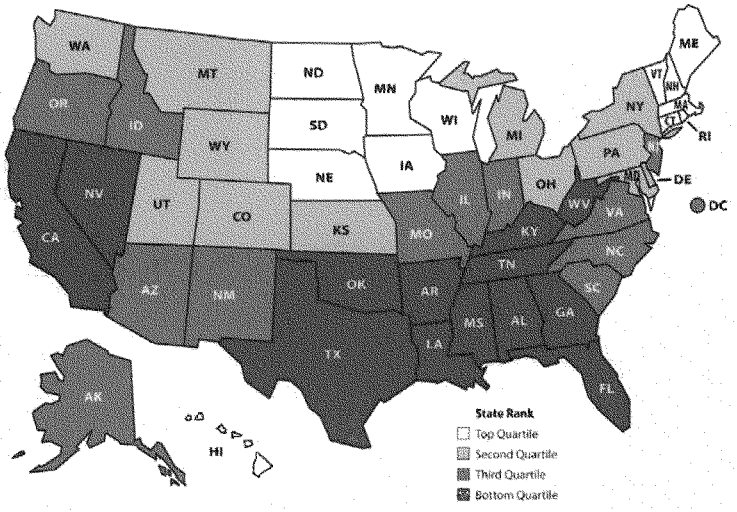
Source: A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53.

Figure 14. Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003



[a]2002 [b]1999 [c]2001
*Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

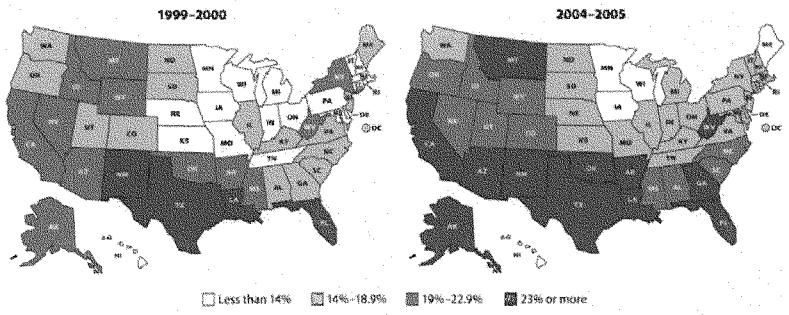
Figure 15. State Ranking on Overall Health System Performance



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

ACCESS

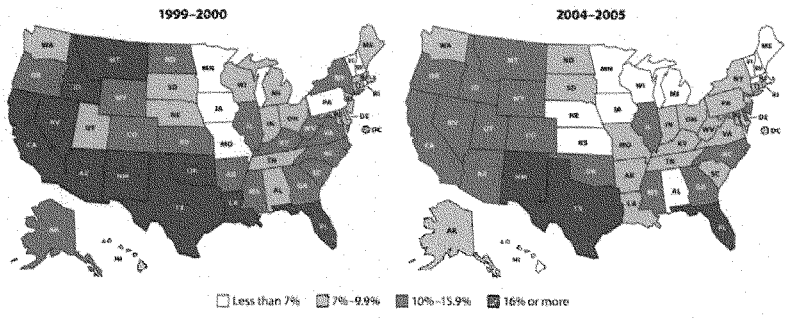
Figure 16. Percent of Adults Ages 18–64 Uninsured by State



DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

ACCESS

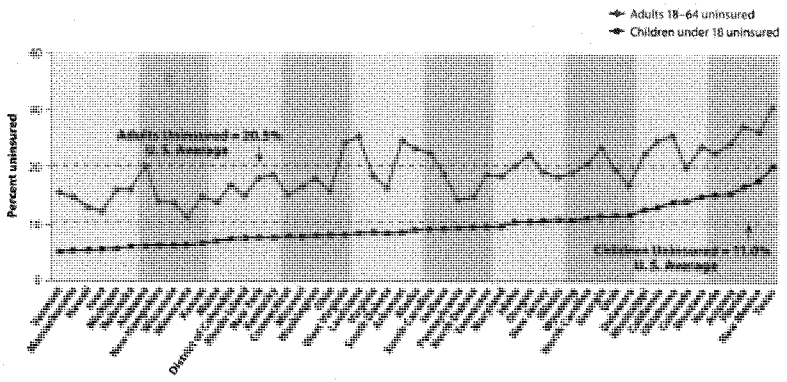
Figure 17. Percent of Children Ages 0–17 Uninsured by State



DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

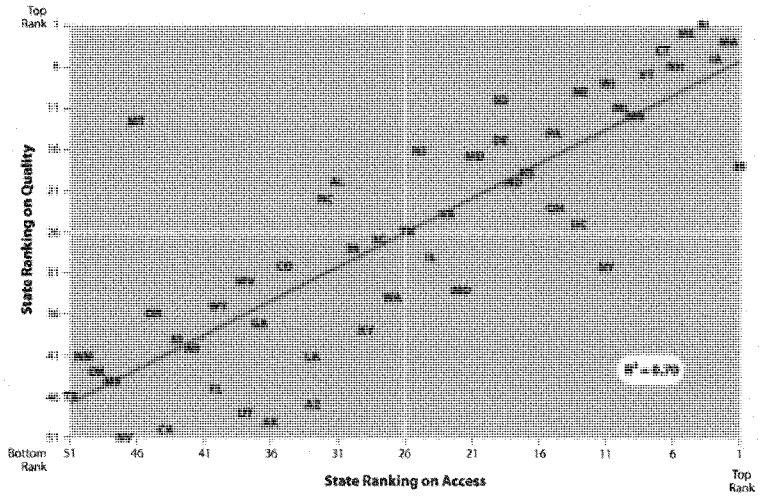
ACCESS

Figure 18.
Percent of Adults and Children Uninsured by State, 2004–2005



DATA: Census Bureau's March 2005 and 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Figure 19. State Ranking on Access and Quality Dimensions

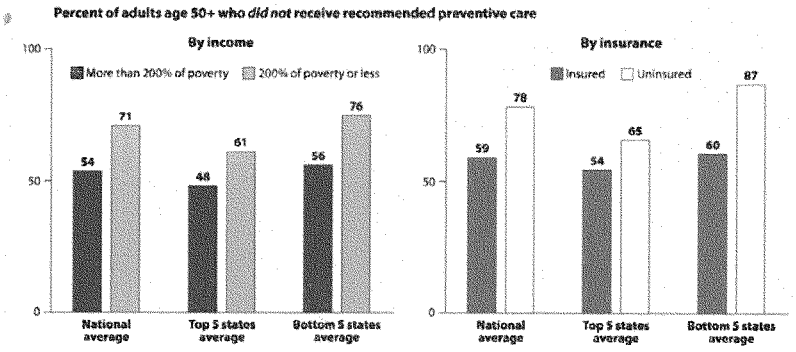


SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

EQUITY

Figure 20.

Lack of Recommended Preventive Care by Income and Insurance

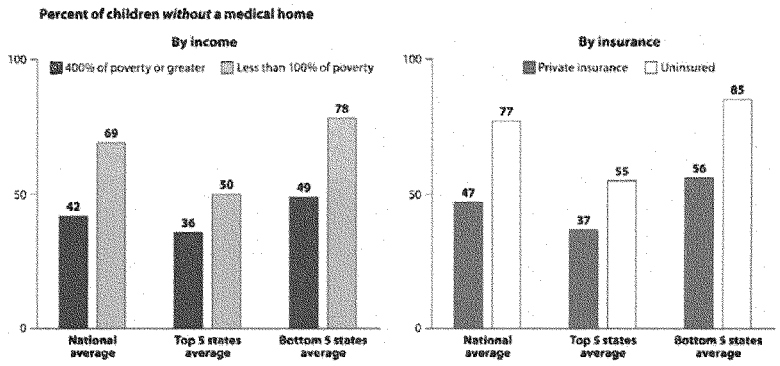


Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured.
Bottom 5 states refer to states with largest gap between national average and low income/uninsured.
DATA: 2002/2004 BRFSS
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

EQUITY

Figure 21.

Absence of a Medical Home by Income and Insurance

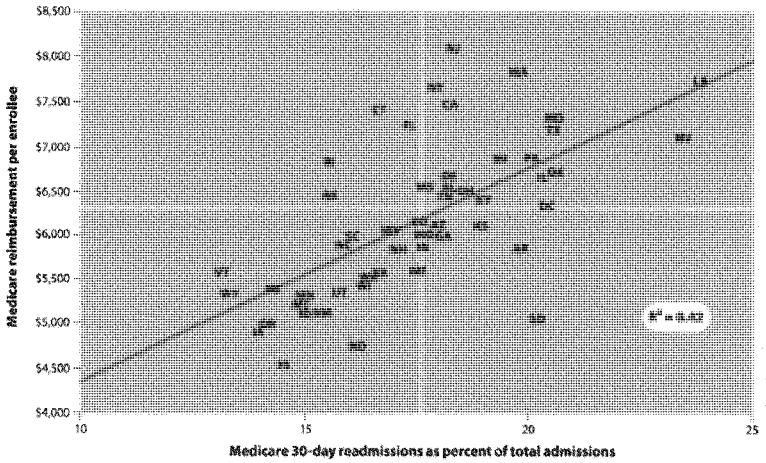


Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured. Bottom 5 states refer to states with largest gap between national average and low income/uninsured.
DATA: 2003 National Survey of Children's Health
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

AVOIDABLE HOSPITAL USE AND COSTS

Figure 22.

Medicare Reimbursement and 30-Day Readmissions by State, 2003



DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

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An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part 1, Insurance Coverage (March 2007). Sara R. Collins, Karen Davis, and Jennifer L. Kriss.

Slowing the Growth of U.S. Health Care Expenditures: What Are the Options? (January 2007). Karen Davis, Cathy Schoen, Stuart Guterman, Anthony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum.

The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans (December 2006). Paul Fronstin and Sara R. Collins.

U.S. Health System Performance: A National Scorecard (September 20, 2006). Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum. *Health Affairs* Web Exclusive.

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Creating Consensus on Coverage Choices (April 23, 2003). Karen Davis and Cathy Schoen. *Health Affairs* Web Exclusive.

Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets (May 2002). Jon Gabel, Kelley Dhont, and Jeremy Pickreign.

Chairman CONRAD. Thank you very much.

Let me go to the question of comparative effectiveness. Very striking in your testimony, Dr. Collins, is the wide difference we see across regional lines in the country.

Dr. Nichols, you mentioned comparative effectiveness along with electronic records and changing incentives. How do you see comparative effectiveness being employed? One of the things, I think it is pretty clear we have a common agreement that comparative effectiveness has to be part of the solution. In fact, in our budget we have a reserve fund for comparative effectiveness.

Dr. Nichols, how would you employ it?

Mr. NICHOLS. You know, Mr. Chairman, I think that is the question. I would offer the following example: let us start with something concrete, what we do now at the FDA. Right now to get a drug approved a company has to show that the drug is safe and effective, say it does not have untoward side effects, and beats a placebo. With all due respect, prayer beats a placebo.

So maybe we should think a little bit about raising the bar. What if you said you have to show against existing treatments and for which subpopulation?

Now that will take longer so you have to give them the right incentive. You have to give them a longer period of exclusivity.

But the fundamental point, show us at the point of decision about whether to go forward with widespread marketing, that it beats existing treatment options and for whom.

Then you take that information. And what I would do, sir, is put the information in the public domain. That is why the creature that makes the information has to be, in my view, a combination public/private partnership. The research has to be done in academic medical centers so we believe that. And the funding has to come from the Government because we are the ones producing the public good of the information.

Chairman CONRAD. Let me direct you to—just interrupt you for a moment if I could. Dr. Milstein came here supporting specific legislation. Have you looked at the Gregg-Clinton proposal?

Mr. NICHOLS. I think it is a step forward. I think it is a very good idea to allow analysis of the data inside the Medicare program. I am, frankly, not committed to the notion that the individual physician is the right unit. I think, as Arnie talked about, there is difficulties with numbers of patients of different kinds so that, as he put it, the density of a patient population. It may be better and smarter to aggregate over groups. There may be different ways to do it.

But as a way forward, using the data we have now, is certainly a good way to, in a sense, create rough rank order of who is doing extremely well.

I think the example that Senator Allard talked about of Intermountain Health Care in Utah, Senator Wyden implied Kaiser in Oregon, Geisinger in Pennsylvania, Mayo in Minnesota, Henry Ford in Michigan. A lot of folks are doing this right.

But what we do not have, and that is the next step, we do not have a powerful system of driving the incentives through the system to make everyone do what other people know is working.

Chairman CONRAD. Exactly.

Mr. NICHOLS. And that is where I would submit Medicare can play a major role in buying smarter by linking payment to outcomes. What if we said, if you are one of those docs managing the diabetics better, you get more money? Hey, what a concept. I suspect we will get—so you take this information, you put it in the combination public and private buyers we have now, and they work together to drive the incentives. That is the best way to go forward, rather than having one-size-fits-all.

Chairman CONRAD. Ms. Collins, on the same question, comparative effectiveness, how can that best be employed?

Ms. COLLINS. I think it is very important, in terms of just from the benefit perspective too, to think of how we were structuring benefits. So once we have done the difficult work of looking at what is comparatively more effective, that our benefit designs steer people in the direction of using higher quality, higher valued services.

Right now we do not have that very much in our benefit structures. People are directed toward overusing ineffective services and underusing services that could be very effective. So the benefit design is a very important piece of thinking about comparative effectiveness.

Chairman CONRAD. And who should have the responsibility for that benefit design and using comparative effectiveness measures? Where should that responsibility lie?

Dr. Nichols was talking about in the context of FDA. I am wondering about with respect to individual doctors making judgments about what treatment they are going to use for specific illnesses. The thing that has never been clear to me is how do we translate this data down to that individual doctor and incentivize them to use the best practices?

Mr. NICHOLS. It comes back to what I think Senator Whitehouse was getting at, and that is we have to have a system of information, an infrastructure if you will, so that not only do you have an electronic record of the individual patient, but each clinician/patient encounter should have access to the best practice information that the Intermountains, et cetera, developed. So that when presented with here is this patient, this problem, here are my choices, here is the one that seems to work best for this kind of patient.

This decision support tool dimension of the electronic information infrastructure may be as important. That is how you are going to get the savings from the RAND study, is getting that information out there to the clinician/patient encounter. And also then paying them more when they do well and, perchance paying them less when they do not do as well.

Chairman CONRAD. Thank you very much.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you.

Boy, there are so many things I would like to pick up on but I think the first one is I would like to emphasize what you said about the potential hazards of taking comparative effectiveness analysis and trying to drill down to individual doctors.

That concept just scares me to death, because I am so concerned that by the time you have drilled down to that individual doctor and you have figured out that the reason Dr. Whitehouse is showing lower costs is because he knows that he is not very good at this

stuff and he is referring all of his tough cases to Dr. Nichols, who is really the local expert in this matter. As a result, in the community known to be the local expert, as a result gets the toughest cases, as a result has bad outcomes. By the time have gone down into their patient records and teased out that data, you have such a regulatory load that this system now has to carry, and particularly run through private insurers is so gameable that it will make, I think, our present claims processing nightmare look like a walk in the park.

So I am really interested in trying to figure out ways to—it is finally important that we do this. I just think drilling down that far with our present level of capacity is really problematic.

My thought at this point would be to do it more regionally and hold basically regions and States accountable for their performance and pay more in certain areas than others. It is a little bit rough justice. But that really then incents the local community to sort out its own affairs and to do the kind of internal work that is necessary.

My sense, I will ask you to react to this after I make this last point, my sense is that we are so primitive at this point in developing comparative effectiveness and in having the institutions in place to really work this issue, that we are far better off as a country if we push some of this down to the more local level where people have existing relationships, where they trust each other, where they see each other in the market on Sundays, and where you can kind of let 1,000 flowers bloom, let the laboratories of democracy do their thing, and take more advantage of the innovation that can develop at that level.

So there is a series of different thoughts but I would like you comment back to me on them.

Mr. NICHOLS. All of them are good. I would say unambiguously, we are not going to be successful in translating incentives to a medical marketplace unless the physicians behavior is indeed reflected in both what they get paid and the outcomes over which they have control. So this notion of—that is why I am worried about the individual physician thing, as well.

However, I would say it would still be useful to know which of these physicians are better. But maybe you do not want to make it public and maybe you do not want to tie payment to that specifically. But you want to go and say you know what? You are an outlier. What is the deal? What do they do at Intermountain? They go down the hall and talk to them. It is exactly the kind of local community conversation you are talking about.

So one idea would be to say OK look, here is a referral network, you know Commonwealth has done a lot on high performance networks. Here is a de facto referral network, let us just say in Providence. Let them choose themselves to join this group over which we hold that group accountable. Then they are referring to each other and then they really have a stake in it and, I would submit, a control over it. And we are much more likely to get physician buy-in.

The worst thing we could do, in my view, is to rush headlong into this area and turn the physicians against us. I have much scar tissue from 1992 and 1993. We are not going to reform the health care system if the physicians become our enemy. Just a thought.

Senator WHITEHOUSE. A related thought is that if you are focusing on extracting out of this information that we have the best practices that actually exist out there and then setting them up as the model for everybody to work toward, rather than setting up a definitional thing of who is good and who is not good, you get the same place. It is far less gameable. And there are ways within the existing administrative apparatus of Government, particularly State Government, where you could have meetings in a sensible way of figuring out what those best evidence practices really should be.

Mr. NICHOLS. That is extremely important, and I would submit that is the only real solution in the long run. We are going to get where we want to be when every physician wants to be as good as that best practice outcome. And they are going to want to do that if we both show it to them. They need to know—there is too much information, they cannot possibly process it all. And second, to have incentives so they do not get screwed financially by pursuing the right strategy.

And that is why we need both of those things. Absolutely. No question about it.

Senator WHITEHOUSE. I appreciate your testimony.

Chairman CONRAD. Senator Stabenow.

Senator STABENOW. Thank you, Mr. Chairman.

Just to continue on the whole discussion on comparative effectiveness for a moment. First of all, there are terrific software packages out there now. And it would be interesting, Mr. Chairman, I think to show some to the Committee as it relates to these issues. Because there is already software out there. There is already efforts going on on comparative effectiveness. That would it be, I think, very interesting for us to take a look at.

But to take a step back in what you were saying in terms of physicians, we find a situation where we have either been freezing or proposed cuts in Medicare reimbursements for physicians. Then we say to them we want you to go out and buy this hardware and this software and be able to spend all this money. And by the way, you will get the least savings in the system. The big savings goes to the Federal Government and the hospital systems.

In Michigan, where we are actually, I think, one of the States really moving along aggressively in health IT, they find that it is most difficult to get the physician to come on board. The hospital system sets up out health IT but it is the cost and et cetera.

So that is one of the reasons Senator Snowe and I have been proposing that we do some simple things like accelerated depreciation on costs for physicians to be able to get equipment, payments that are not only a higher payment for quality but a higher payment for use of technology, so that we are rewarding what we need. Because we are never going to be able to compare anything until we get these folks on electronic records and get a common system.

So I keep going back to how do we get this started so that we are rewarding every provider? Medicare could easily be rewarding providers that are using these systems and then go to comparative analysis after we get them on board.

So I hope that we are going to be able to move this, to be able to do some things in that area.

A different kind of question. I want to go back and actually ask Dr. Nichols, you to visit something you went over very quickly. I want to be the devil's advocate here today, as we are all talking about individual mandates.

You talked about three different approaches. I would agree with you on the employer mandate personally. I do not believe that is the way to go. Individual mandates, possibly, depending on how we do that.

But you skipped over the first one, Medicare for all. I would like you just to go back and revisit. When you say the public would not accept that, my mother I think would wrestle me to the ground if I tried to take her Medicare card away. The truth is it is the only universal system we have. Politically it may not be viable to go to that approach. But from a substantive standpoint it has choice, you get basic coverage. If you want to add doctor visits or home health coverage you sign up for Part B, you pay more. You want prescription drug coverage, sign up for Part D, you pay more. It is 2 percent administrative costs, much less than the 15 percent to 20 percent in the private sector.

I guess I would just like you—I am not so sure it is the public that would not accept it. I think politically, because of all of the interests, it would be difficult to pass. But the public, I think, thinks Medicare works pretty while.

So I wonder if you might just speak a little bit more substantively to Medicare.

Mr. NICHOLS. I think it is an excellent point. I would say I am basing my observation about the public on the speaking that I do around the country. I am very lucky, I get to talk over the country. I would say between Philadelphia and San Francisco people are nervous about having one-size-fits-all for them. They think Medicare works great for mom, and they are looking forward to getting there. That is correct. It is a safe thing and it works. It is the most popular program probably our country has ever had.

But that does not mean they are willing to accept a Government control over what their choices are compared to their——

Senator STABENOW. I would just stop you there.

Mr. NICHOLS. So they are worried about it. That is all I am saying. I would submit the bill that is in, I believe, the House now, I believe it is Representative Stark's. It is basically Medicare as it for all, which allows the private plans to compete. I think that is the way to go if we are going to go that way. I think that would preserve the choice.

Go back to what is our fundamental problem, Senator? I would submit is a lack of information, which leads to a lack of trust. The reason we had the backlash against managed care was not that some managed care plans were not outstanding in quality, some in your State you know. But they could not convince the people that they were better. And they thought employers were forcing them into them and they did not trust them. And some of them, of course, did behave badly. No question about that. But the point is they did not have information to convince them of high quality. So choice became a proxy, a protection, a safety valve. And that is why I think choice is so important.

So if you had choice in the Medicare for all, then I think that would be something that would be more talkable.

But I would also submit, and Peter Orszag's testimony last week made it clear again, over time the rate of cost growth in the Medicare program basically is the same rate of cost growth as the private sector. It has done no better and no worse.

Now this is no shock to people like Sara who understand the system. It is all one system, of course this is true. But the point is we have not done better at buying, as a very concentrated single buyer, then the private sector did as well. Why is that? I submit the reason—you come with me to Senate Finance and I will show you the reason. It is because basically the Medicare program, which is an insurance program for our most vulnerable people, is also unfortunately in real life an income support program for mediocre providers.

Democracy will not let us be as demanding as we would like to be.

So I think the cost control potential and the concern about choice is real. What I believe, Senator, is that if we set up a system where we had one big marketplace and there was a lot of competition for it, then that system could work in lots of different ways. It could evolve in lots of different ways. We share the same goal.

Senator STABENOW. Just a final comment, Mr. Chairman, and that is in asking that question I was assuming that there would be that private choice in Medicare. Going back to my mother, she is actually in an HMO and loves it. That is not what I was assuming.

But I would also say, just as an editorial comment, that we also, in the Medicare prescription drug piece, I believe, have higher rates because negotiation is prohibited.

But nonetheless, I would just say before we dismiss—I mean I understand all the realities of going with the third choice you looked at. But I do think it is just important to speak about the fact that we do have a system that provides choice, that adds on based on paying more depending on the services you want, that has worked well for the people that it covers.

Chairman CONRAD. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. And I am sorry I did not get to hear all of the comments from the two witnesses because both of them are as good as it gets in American health care policymaking. We would not have had a Healthy Americans Act if it had not been for Len Nichols and we are very, very appreciative of that and look forward to having your counsel.

Ms. Collins, you and Karen Davis have been doing good work in this field since I have been involved in it and I really appreciate your contribution, as well.

I wanted to ask a question that has had me baffled for a couple of months and see if you can walk me through it.

You all did, back in April, an analysis of the various reform proposals. And we were very flattered that you called the Healthy Americans Act one of the leading proposals.

There was one chart that I wanted to ask you about. Essentially I and Senator Edwards and Senator Stark, all of us seek to cover all of the uninsured, the 48 million. And you put the Stark pro-

posal at covering 47.8 million and our proposal at covering 45.3 million. So we will want to work with you on that analysis. But that is not my question.

My question is on the chart it says that the Stark proposal will cost the Government $154.5 billion. And then you said that our proposal would cost the Federal Government $24.3 billion. So you look at that chart, and I need you to just walk me through it. You scratch your head and you say by this chart it would cost $130 billion difference between the Stark cost and our costs to cover the I guess 2 million people that you have calculated was the difference.

Congressman Stark has done a lot of good work on health care over the years and we have worked with him and I want to sort this out.

But can you tell me what that chart really is all about? Because I do not think—I do not think he intended that. And I want to sort it out because it is a remarkable difference in cost between the two proposals, the Stark Medicare for all approach and the Healthy Americans Act.

Ms. COLLINS. I think those are really good points and actually the Lewin Group modeled both proposals, so using a similar model, a similar set of assumptions.

But the major difference in terms of the Federal costs are the fact that you have more financing sources in your proposal. Because of the wage cash out, there is some newly taxable income, so it increases the revenues that can support the program.

In the case of the Stark provision, households can have a major savings in premium, employers also realize major savings. So if there were a financing component that was stronger in the Stark proposal, that size of the Federal Government's share would probably go down.

In terms of the overall savings, we tend to really focus on the Federal costs on these proposals. The overall health system savings are also a very important component of evaluating all the proposals, and these two proposals in particular. Both proposals have a very significant risk pooling mechanism. The Stark proposal, in terms of Medicare for all, and then Senator Wyden, your proposal in terms of these large regional purchasing cooperatives. This is very important in terms of achieving overall savings.

Administrative savings are huge in the United States. And pulling everybody into large risk pools is very important in terms of gaining control of health care costs. But that is the major difference.

Senator WYDEN. That is a very thoughtful answer and the pooling question goes to the point Senator Stabenow made as well, with respect to consumers and their having bargaining power and the ability to get a fair shake is something that clearly would be changed.

Nothing, in my view, works unless you have the kind of private insurance reform Senator Stabenow is talking about, the kind of pooling that you are talking about, Dr. Collins. And we would like to work some more with you on the underlying numbers that went into this because as soon as I saw that I said to myself I know my Chairman, who has been so kind to work with me on these years,

is going to look at these charts in great detail and I am going to have better answers than I have.

But you and Dr. Davis had done great work for a lot of years. And to Len Nichols, I have thanked him before. All of those two a.m. e-mails kept us going when we were trying to put together the Healthy Americans Act and we would not have a bipartisan bill without you, Dr. Nichols.

Thank you, Mr. Chairman.

Chairman CONRAD. I am going to do an usual thing here but I would like to ask Senator Wyden question. That goes to the question of pooling.

I have been intrigued with the German system, maybe because in part I am a little German. And at the heart of their system, as I understand it, and maybe the two witnesses know something about these foreign and international systems, as well. They take advantage of large pooling in employer groups.

In the Healthy Americans Act how do you get to the large pools? How is there a translation from the cashing out feature in which the employer provides to the employee the cost of their current policy so that the individual can go out and buy an equivalent policy? How do they make that leap to get into a large purchasing pool which will give them leverage?

Senator WYDEN. We create, Mr. Chairman, a statewide pool. And we also make it possible for there to be a regional pool. So that, for example, my sense would be the first thing that would happen on the East Coast of the United States is you would probably have a New York, New Jersey, and Connecticut pool. They might call it eastern states regional purchasing organization. So essentially all the money is collected through the Federal tax system and pooled. You could have, for example, a Dakota health help agency, North Dakota and South Dakota going in to pool the dollars. The key, of course, is to have, as you have suggested and the Germans do, a big enough group of people so as to spread cost and risk.

And then you get to the point that Dr. Nichols has been making, is that you also can make markets considerably more efficient in that kind of way because you do not have the problem that we have seen of late, some pretty affluent people who just do not buy coverage.

Chairman CONRAD. Let me say that I am very concerned about State-focused pools. Perhaps it is because I come from a State with a modest population. But I think we all know to really get the leverage advantage you have to be part of a large pool. We just do not have the population, in North and South Dakota. We combine the two States we have 1.4 million people.

I think it is going to take, and that is what I am intrigued about the regional opportunity. This is a conversation for a more extended session at some point. But that is very intriguing to me, how we get people to have the advantage of being part of a large pool.

Senator WYDEN. If I could just offer one other thought, Mr. Chairman, I think you have your hands on it. You do not make the pool work unless they are big enough. So if the Dakotas decide they want to go in and bring in several other States—we found in New York and New Jersey——

Chairman CONRAD. We might even consider going in with Montana.

Senator WYDEN. Montana—I will leave that to you and Senator Dorgan and all the other good folks from the region.

I was struck, as I talked to people in New York, is people said well, I work in New York, I live in New Jersey, my kid is in school in Connecticut. Clearly you are going to need to have some capacity to do what we are all talking about. I very much want to put this in the context Senator Stabenow is talking about.

Because if you are going to start something like this, people are going to need to know how is it going to work right at the outset. Because first impressions are everything. We thought that the idea of coming up with a win for the workers and the employers right at the outset was something, as you said Mr. Chairman, we have laid out in the basic structure. But there are scores of details that would have to be addressed before you could go forward and.

Chairman CONRAD. Let me just say, I think at future hearings for the Committee we might want to have a panel that would look at the various options, single-payer, employer mandate, individual mandate. I think that would be a very useful panel.

I think it would also be very useful for us to have a future look that would include electronic records, changing the incentives, and comparative effectiveness, that that would be a very useful—and I would like to work with Senator Wyden, Senator Stabenow and Senator Whitehouse, who I have deputized be a subcommittee of the Budget Committee, to work on who might be good witnesses for those various hearings and how we might proceed to hold hearings on those issues.

We have been joined by very valuable member, Senator Nelson of Florida. Welcome, Senator Nelson. Please proceed.

Senator NELSON. Let me ask the good Senator from Oregon, in your proposal how do you take the employer mandates—no, let me rephrase the question.

How do you take the existing system of employer-sponsored insurance and how do you transition those people into the large pools?

Senator WYDEN. The Senator, of course, has asked the big question. We come at it this way. Essentially we got into this predicament after World War II. We had a situation where there were wage and price controls. We had all of these wonderful troops coming home. And there was no way to get them benefits. Essentially, it all got pushed back on the employer. It was factored into the cost of goods and services and we could pretty much handle it at that point. We were not faced with a global economy.

Today what you have is those employers in Florida are competing against people in India and Asia and all over the world, and you cannot spot your competition 15 or 20 points the day you open your doors. The premiums go up 13 percent a year in Florida and your foreign competition has socialized medicine. You cannot be competitive.

So the big idea in this legislation is to cut the link between health insurance and employment. And the way we do it is through a transition period. So that if you have a business in Florida that say pays the worker $40,000 in salary and $12,000 in health care

benefits. at the outset the business pays the worker $52,000 in compensation. We adjust the workers tax brackets so they do not experience a hit for the additional compensation. And then we reform the private market so that that person, with the additional money, can go out into a private market where the health insurance companies cannot cherry pick and cannot discriminate against you if you have had an illness and the like. And the Senator, because he was an insurance commissioner, knows how widespread that problem is.

But we tried to come up with a transition so that the worker wins and the employer wins at the outset. And we were able to get Andy Stern, the head of the Service Employees Union, and Steve Burd, the head of the Safeway Company, to essentially be our bookends for labor and business, saying if you make the transaction this way, labor and business, it is looking for a win for workers and employers will say let us give it a shot.

Senator NELSON. And then the employee, the insured, would then take that money that otherwise his employer, and he would go out and he would purchase from these large pools. And therefore you could purchase it cheaper because you would spread the risk over quite a few number of people instead of just the risk of the population of the employment.

Now how do you guarantee that, in fact, the insured, the employee, will go out and buy it become the insured?

Senator WYDEN. Florida, of course, is in the enviable position that the Dakotas and Oregon, that we are not because you will have a lot of people for purposes of pooling, and certainly a number of major insurers will find that market attractive.

What we said in this legislation is all right, we are not going to put people in jail if they do not buy the coverage. That is what happens if you do not buy auto insurance, we put you in jail. We have not going to do that. So we set up a regime of essentially financial penalties so that if the person did not buy the health coverage they would get nicked with a financial penalty. If they eventually go the hospital emergency room, which is usually what happens, they get signed up at that point. So there are various points through State services where you would sign them up, a way to have a default sign up arrangement so that if we learn you are not covered.

And then employers will be involved in signing people up as well. So the idea is to have as many different checkpoints that are practical, not intrusive but practical, to get people signed up, recognizing that now in America you have to buy auto insurance and certainly some people do not do it.

Senator NELSON. And under your concept who regulates the product that is offered to the consumers?

Senator WYDEN. Still regulated by the States. We do not upend McCarron-Ferguson and the process of current State insurance regulation. We do make those changes that Senator Stabenow spoke eloquently about to make sure it is a different product.

I think the Senator knows this is an area I feel very strongly about. I think probably the thing I am proudest of in my time in the Congress is having written the Medigap law, which I think the Senator remembers back before we had that, you would have seniors with a whole shoebox full of insurance policies. Most of them

were not worth the paper they were written on. We got that Medigap law through, working with the National Association of Insurance Commissioners.

So we have to get this insurance reform piece right and we ought to keep it with the States.

Senator NELSON. In the case where you would pool several States, then you have some amalgam that between the insurance commissioners of those States they would regulate the product?

Senator WYDEN. That is correct. It would almost be—I think from a legal standpoint we were advised by the Congressional Research Service to not call it a compact. And Len me know something about it. But it works the same way. You could have, and this will be especially important for States like Oregon and the Dakotas and Rhode Island, not so important for Florida, California and Texas, but we have to have the opportunity to create a big enough pool.

Senator NELSON. Did you ever think about going to pools beyond States, so that you get millions of people in the pool?

Senator WYDEN. That, of course, means that you are going to have the debate as to whether it is going to be a single-payer or a system that involves a less expansive role for Government. We felt that creating the kinds of pools that we envision, particularly with regional kinds of pools, got it large enough.

But this would be something that would surely be debated and my sense is that people who are for some version of single-payer or another, Medicare for all or some other version, would clearly want to say all right, if we cannot have one pool, let us have two pools. And we should have that debate.

I think that the feeling of myself and Senator Bennett is you got to have something which gives you a big enough pool for bargaining power and still you are able to structure enough private choices so as to have some competition in the marketplace.

Senator NELSON. Mr. Chairman, I will just say in closing that Senator Wyden has corrected one of the deficiencies that is often missed around here. For example, there was a U.S. Chamber of Commerce highly intensely lobbied effort to take the same concept of pools.

In this case it was more like a trade association, for example realtors. You cannot afford it if you are a single realtor. But if you could bank all of the realtors together, then you could spread the health risk over that much larger group.

But the fatal flaw in it was that they had no regulator. With the result that were that version to become law, you would go right back into what we have. You would have the advantage of a larger group but then the insurance companies would start cherry picking as the group got older and older and sicker and sicker. And there is no regulator looking over their shoulder.

There was, and I do not remember who it was filed by, another version that did allow the State regulators to get involved. And I would have people coming up here just begging me to cosponsor this legislation. I would sit down and explain to them the bottom-line result is going to be exactly the opposite of what you want. What you are trying to do is get relief on the high premiums that you are paying. But if you take the regulator out of the mix then

inevitably the premiums is going to go up and the coverage is going to go down.

Chairman CONRAD. The Senator is entirely correct. I had the same thing. I had many people from my State, some of my closest friends, come to me and urge me to support that legislation. When I showed them what it would intersect with our State law and would have created a system of cherry picking, if you would have had an outlier, if you had somebody in your group that was unhealthy, that person would be excluded from coverage and you would have had a system of insurance for the healthy, not for those who had a medical condition.

Unfortunately that would have been—would not have accomplished what the whole purpose was.

Let me just say and ask Senator Wyden in closing, we have a vote that is about to occur on the floor and we will have to shut down the hearing.

There is no restriction, as I understand it, in this legislation as to how many States might decide to pool together?

Senator WYDEN. That is correct. And I think you, Mr. Chairman, and Senator Nelson raise very important points. We need to have that debate and clearly the pools have to be big enough to make a real difference. There is no restriction on the number of States that could pool or how many States could go in together.

Depending on the size of the pool, we would have the debate that Senator Nelson's question really triggers is at some point I guess if you say all the States can join in one pool, everybody says that is the single-payer model and then you bump up against a different set of political challenges.

Chairman CONRAD. And I do not think that would be—I do not think that is what would happen. I do not think you would have a situation where all of the States would go together. I think what you would have is you would have these regional pools and maybe would have more than a regional pool. Maybe you would go outside of your region for diversity sake, in terms of reducing risk to the pool.

I think that would be very healthy to have different pools because then you could look at the experience of the different pools and see what best practices result in savings and in improved health care outcomes.

Senator WYDEN. And there are some visionary people in the insurance industry who I think would be willing to accept it. Normally you would think that they would automatically want to have the smallest possible group so as to not have some clout. But I think a lot of them are coming around to exactly the kind of thing you are talking about.

Chairman CONRAD. Let me know thank the witnesses. We appreciate very much your contribution to the work of the Committee. I thank all of my colleagues who have participated today.

We are going to continue this series of health care hearings because we understand the critical importance of making progress.

Thanks to all who have participated today.

[Whereupon, at 11:51 a.m., the Committee was adjourned.]

HEALTH CARE AND THE BUDGET: OPTIONS FOR ACHIEVING UNIVERSAL HEALTH COVERAGE

TUESDAY, SEPTEMBER 11, 2007

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Kent Conrad, Chairman of the Committee, presiding.

Present: Senators Conrad, Wyden, Stabenow, Cardin, Sanders, Whitehouse, Gregg, Allard, and Graham.

Staff present: Mary Naylor, Majority Staff Director; and Scott Gudes, Staff Director for the Majority.

OPENING STATEMENT OF CHAIRMAN CONRAD

Chairman CONRAD. The hearing will come to order.

I would like to welcome everyone to the Budget Committee this morning as we discuss options for achieving universal health care coverage.

I would like to particularly welcome our witnesses today: Dr. Henry Aaron, Senior Fellow at the Brookings Institution; Dr. Sherry Glied, Department Chair and Professor of Health Policy and Management at Columbia University's School of Public Health; and Janet Trautwein, the Executive Vice President and CEO of the National Association of Health Underwriters.

Welcome to all of you. The Committee is very appreciative of your helping us with the work of the Congress.

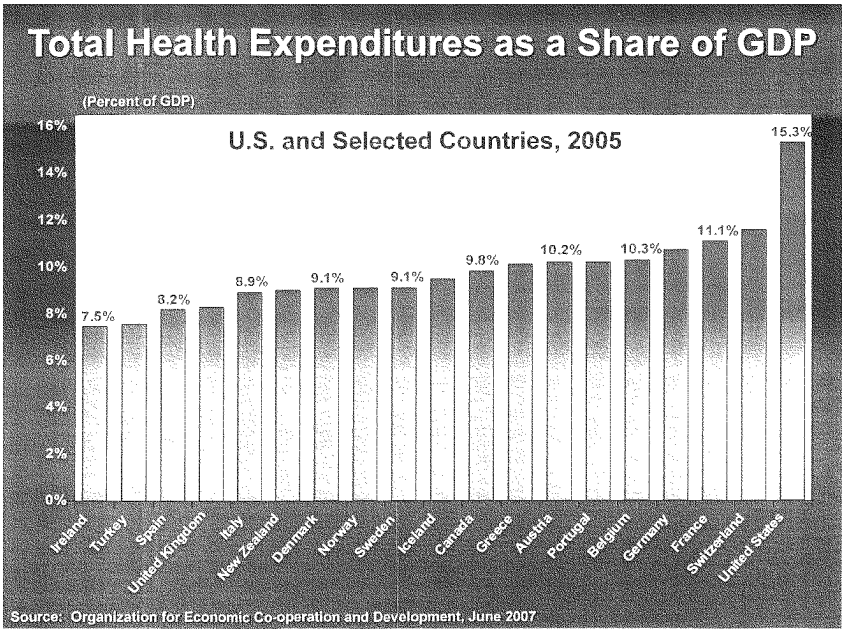
This is our fifth hearing this year specifically on health care and its impact on the budget. The fact is that rising health care costs, even more so than the coming retirement of the baby boom generation, represent the most significant threat to our Nation's long-term fiscal security. Solutions should not be put off. The sooner we act, the better.

Part of the solution, I think we have a growing consensus, is that we need to have universal health coverage. Instead of getting needed preventative care, too many of the uninsured are ending up in the emergency room and I think all of us understand that is the most expensive place to extend treatment to them.

Moving toward a universal system would make it easier to coordinate patient care and adopt new health care information technology and best practices. Our health care system is simply not as efficient as it should be. The United States is spending far more

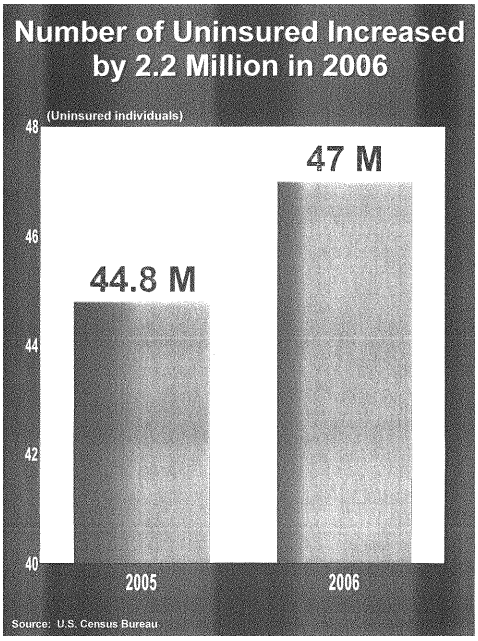
on health expenditures as a percent of GDP than any other country in the Organization for Economic Cooperation and Development. Those are the leading economies in the world.

For example, the United States spent 15.3 percent of GDP on health expenditures in 2005, compared to 7.5 percent in a country like Ireland.

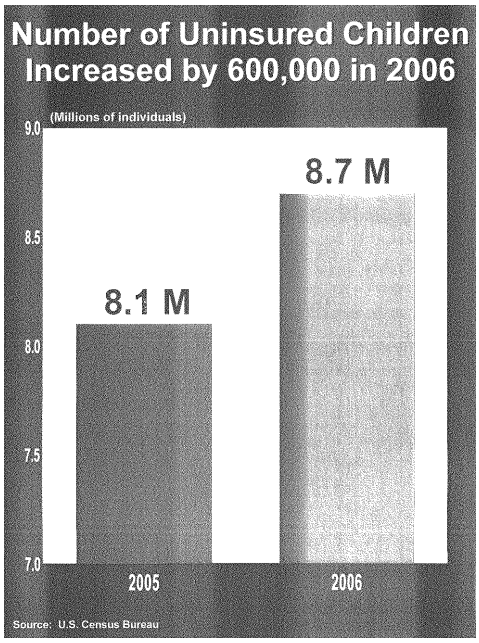


We are spending even more than that, of course, today. I think the latest estimates are we are at 16 percent of gross domestic product. That is between one of every $6 and one of every $7 in this economy is going toward health care, far more than anyone else.

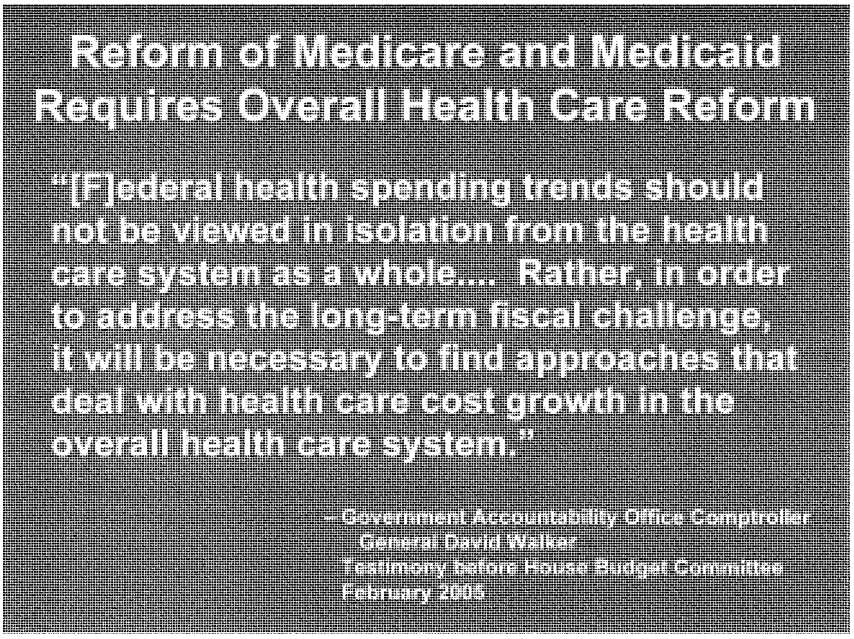
Despite this additional health care spending, health outcomes in the United States are no better than health outcomes in the other OECD countries. And the number of uninsured continues to grow.



In fact, the number of uninsured increased by 22 million people in 2006 to 47 million Americans without health insurance. The number of uninsured children increased by 600,000 in 2006 to 8.7 million children without health care insurance.

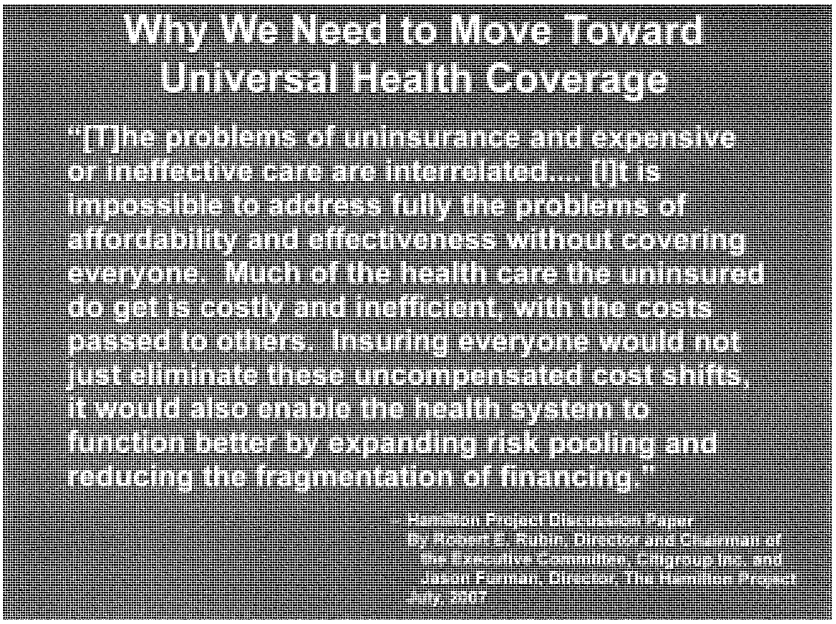


We need to remember that the budget problem we face stems from the underlying rise of health care. Here is a quote from the GAO, the Comptroller General of the United States, David Walker, making exactly that point.



He said, and I quote "Federal health spending trends should not be viewed in isolation from the health care system as a whole... rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system." Moving toward universal health care coverage should be part of that solution.

Here is what the former Treasury Secretary, Bob Rubin, and the Hamilton Project Director, Jason Furman, wrote this summer: "The problems of uninsurance and expensive or ineffective care are interrelated... it is impossible to address fully the problems of affordability and effectiveness without covering everyone. Much of the health care the uninsured do get is costly and inefficient with the cost passed on to others. Insuring everyone would not just eliminate these uncompensated cost shifts, it would also enable the health system to function better by expanding risk pooling and reducing the fragmentation of financing."



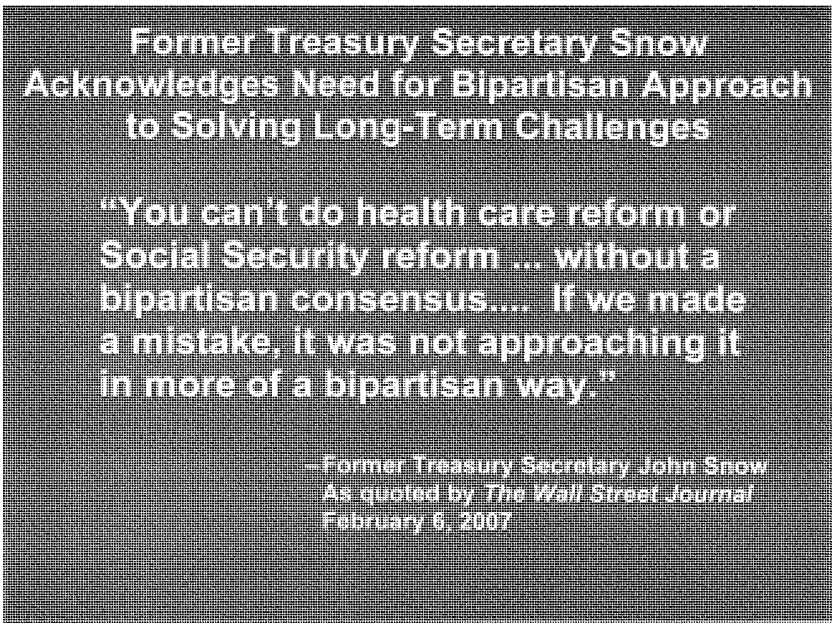
We could build a far more efficient and cost effective system if we could cover those now uninsured.

There are really three basic options for choosing universal coverage.

First, we could adopt a single-payer system, which some refer to as Medicare for all. Second, we could have an employer mandate. Or we could have a mandate on every American to have health care insurance. Those are basically the three options. Or we could have some hybrid approach. We could mix and match to achieve the goal of covering everyone.

But the reality that we confront is that whatever option is chosen must have bipartisan support. These problems are too big to be tackled by one party alone.

Former Treasury Secretary John Snow made this point earlier this year. He was quoted in the Wall Street Journal as saying "You cannot do health care reform or Social Security reform... without a bipartisan consensus... if we have made a mistake, it was not approaching it in a more bipartisan way."



I think Secretary Snow got it right. I think it does require a bipartisan approach. And the sooner we get down to it the better.

With that, I want to turn to the ranking member, Senator Gregg, and once again thank him for his courtesy as we have organized this hearing and ask him for his comments.

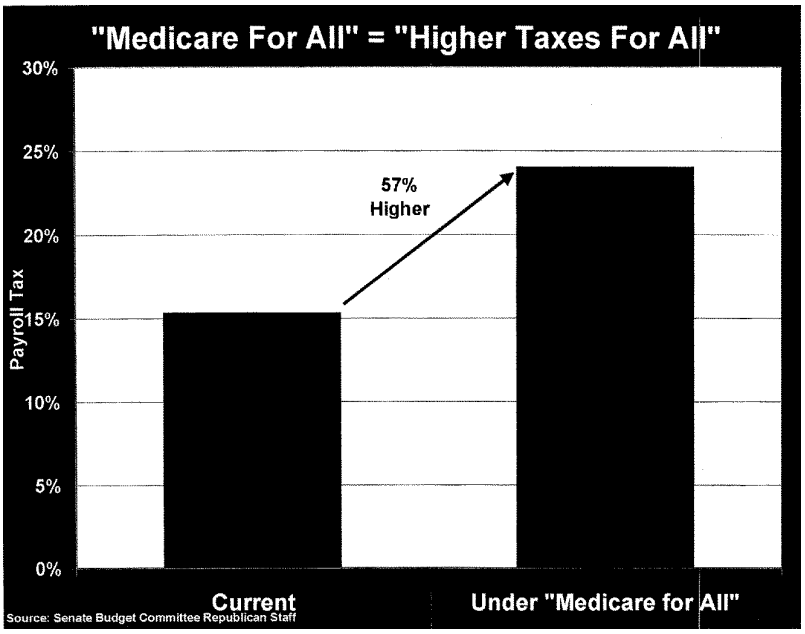
OPENING STATEMENT OF RANKING MEMBER GREGG

Senator GREGG. Thank you, Mr. Chairman.

I thank you for holding this hearing. I want to start where you stopped, which is that—actually start where you started and where you stopped, which is that A, health care is driving the out-year problems which we face as a society from a fiscal standpoint. And also, it's going to be driving our social issues to a large degree because of the aging of the population. And it has to be addressed. And B, it can only be addressed in a bipartisan way.

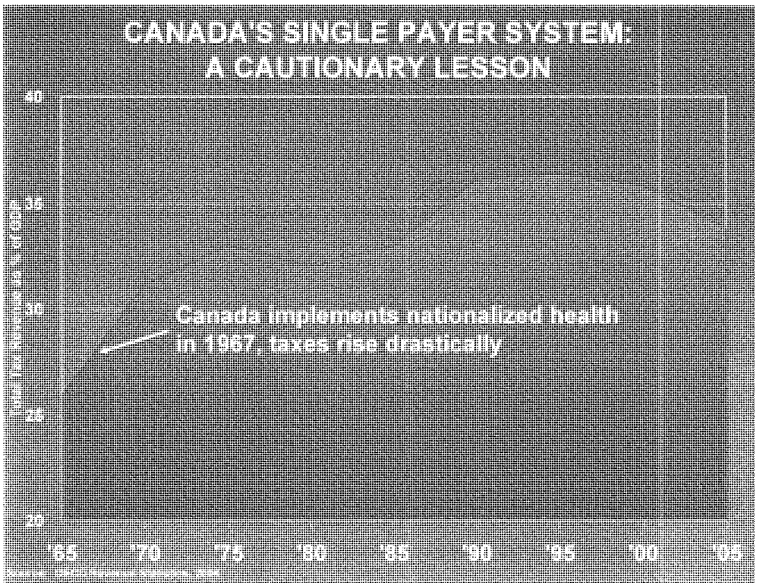
Sitting at the dais today I see Senator Wyden, who has put forward a bipartisan bill in this area, which I am a cosponsor of and which I congratulate him for.

However, prior to getting into the Wyden initiative, which I am sure he will spend some time on anyway, I want to just address the issue of the first of your three options for resolving this, which is a proposal to go to universal health care under a nationalized system. The Kennedy bill, which is called Medicare for all, is the leading example of that. But of course, Senator Clinton has proposed this, Senator Obama has proposed this, Senator Edwards has proposed this. All of the national candidates in the Democratic party running for president have proposed a nationalization of our health care system, having a national delivery system which is controlled by the government.



The arguments for this are that it delivers better health care, that is obviously gives everyone access to health care, and that it costs less. All three of these arguments are wrong. And in addition, the proposal of nationalizing the system as an approach to making sure that everybody gets coverage and having the government run it leads to some other very clear significant problems.

The first, of course, is that it creates rationing. You do not have to go too far to see this. We see it, for example, in Canada, where you have a waiting time that has doubled since they went to a national system, since 1993. That is not since they went to their national system, that is since 1993. In Britain, you have waiting times for cancer and cardiac tests which are 25 weeks.



There is no question but that when you go to a nationalized system you end up with a system that basically rations health care. You are basically putting everybody into what amounts to a national HMO. And the way HMOs succeed is by limiting health care delivery in most context.

In addition, you reduce innovation. It is estimated that if US adopted Canada's national health care system national research and development funding would be reduced by nearly 25 percent, or $77 billion. And nearly one-half of the drugs approved by the FDA would not be available in a national formulary as cost control measures—if a national formulary was used for cost control measures. You are basically limiting A, the availability of drugs, and B, the development of new drugs, things which may cure people, make them better, by going to a nationalized system.

Again, you can look at our neighbors in Canada and our friends across the sea in Britain to see that that is absolutely the case. That is why new drugs are being developed here and not in those nations, to a large degree.

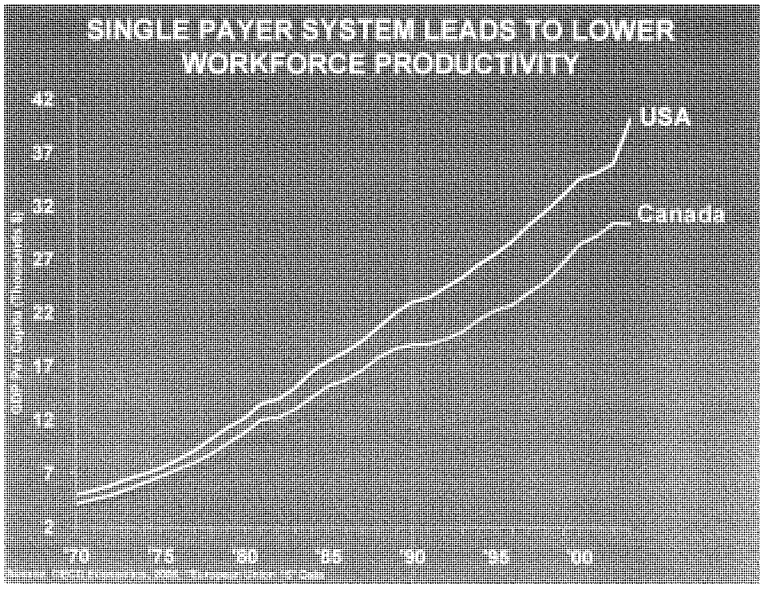
And third, taxes go up a lot. The Chairman makes the point that we spend more per capita as a percent of gross national product on health care than any other country in the world. This is true. But if you look at the tax costs which countries bear as result of going to a nationalized system, you see that their tax burden on the taxpayers of those countries goes up dramatically.

Let us look at Canada, for example. Since they have gone to a nationalized single payer system, their tax burden has jumped significantly and almost the vast majority of that is health care costs.

Let us look at the EU and Canada compared to the United States tax burden. Again, the EU and Canada have dramatically high tax burdens as a percentage of gross national product. And almost all of that reflects health care costs. Remember, in the U.S. health

care cost, we at least have a fairly significant effort in the area of national defense in our tax burden. Canada and the EU do not have that type of national defense commitment in their numbers. So the vast majority of those dollars that are being taxed in those systems are to pay for single-payer nationalized systems universal health care.

The effect of these higher tax systems, what is that? Not only does it mean that people end up paying more of their earnings to the government for a less efficient health care system which delivers a lower quality, rationing, and less research, but it also means that productivity in those countries is not as high because they have a higher tax burden, and the next chart reflects that. The United States' productivity far exceeds Canada and the EU.



I would argue, and I think many economists would argue, that that is in large part a direct function of the tax burden of those countries, which is a direct function of having nationalized their health care system.

In addition, you do not have to believe me on this point. Just look at the number that Senator Kennedy's plan proposes, and that is the next chart. Medicare for all, Senator Kennedy openly proposes a dramatic increase in HI tax and Social Security tax, 57 percent higher under that plan, in order to pay for it. That is a burden that would be put on the American taxpayer.

So even though we may spend more on health care in our society today, moving to a single-payer nationalized system is actually going to cause us to spend a great deal more in the area of tax burden and probably create a less efficient system.

You do not have to listen to me about this less efficient system. I would quote my colleague, the Chairman of this Committee's comrade, Dorgan, from North Dakota because he described what presently exists as the one national health care system that we have

in this country which is truly a nationalized system, and that is the Indian health care system. That is a nationalized system.

Quoting Senator Dorgan on the floor just a few weeks ago he says—he said, of the Indian health care system, which is nationalized system, "You can't ration health care. Yet, that is what is happening. We have a trust responsibility and yet health care is being rationed with respect to Native Americans."

Why is that? Because they have a nationalized system, a Federal system, which is rationally their health care. Quoting a Indian Hospital CEO, "In the Native American population, we are effectively using a system of rationing to be able to provide care for those that we serve."

That is what happens when you go to a nationalized system. The Indian health care system is the best example of what is going to happen to the American system if we go to a system of call it Medicare for all or call it universal health care under a nationalization system. It does not work.

The better approach is the approach suggested by the Senator from Washington, which is to create an atmosphere where everybody has the wherewithal to go out and purchase health care and we use the private markets to do that and we make sure that everybody does that. There are a lot of different variables for accomplishing that, and I have some reservations about Senator Wyden's proposal, but conceptually, using the private marketplace is a much better way to proceed, in my opinion, and it avoids the rationing, the reduction in research, and the massive increase in taxation which would occur if we went to universal system under nationalization.

Thank you, Mr. Chairman.

Chairman CONRAD. Thank you, Senator Gregg.

And I do not take this to mean—as I hear you saying it, you are arguing against a nationalized system, you are not arguing against universal coverage.

Senator GREGG. No, in fact the bill which I have cosponsored with Senator Wyden is a universal coverage. It just uses the private market to drive down costs and make it more competitive and create more incentive for productivity and research.

Chairman CONRAD. I appreciate that and I know that that is the Senator's position. But somebody just casually listening, I think, might have come to the conclusion that you do not want universal coverage. That is not your point. Your point is very clear that you do not want to see a nationalized system as a way——

Senator GREGG. I think we have a problem in the language that is being used because basically the proposal by the Clinton Administration, led by the then-First Lady, which merged the concept of universal health care with nationalization. So we have to figure out how we use better language here. But there are ways to get everybody covered without nationalizing the system, is our point.

Chairman CONRAD. Good point.

I am going to go in a little bit different direction than we have previously at hearings and ask those members who are here already if they would like to avail themselves of a 3-minute opening statement to do so, because let me just say we have some of the most active members on this Committee here today on the issue of

health care, none more active than Senator Wyden of Oregon, who has put forward a very thoughtful, carefully considered plan, which I think has enormous merit. We can question some of the details. That is not really the point of it.

The point is Senator Wyden has stepped out there with a specific plan that I believe, in overall structure, probably has the best chance of advancing.

Senator Wyden, would like to take a few minutes for opening statements?

OPENING STATEMENT OF SENATOR WYDEN

Senator WYDEN. I thank you, Mr. Chairman, for your thoughtfulness and it has generally not been the rule to have opening statements here and I will keep this brief.

I think that essentially 13 years after the last effort, the Clinton plan, we come to an interesting confluence of opportunities. I think it is clear now that Democrats have been right in saying to fix American health care you have to get everybody covered. Because if you do not recover everybody, people who are uninsured shift their bills to people who are insured. So I think you start with that proposition.

Republicans have been correct in saying we do not think you ought to turn it all over to government. It should not be just one kind of government system. I think that is what Senator Gregg was alluding to.

So if you start with that as the basic proposition, then you move to some of the tough calls that are going to have to be made. I think Democrats have to accept the fact that every economist who has come before the Committee says that the tax code disproportionately favors the wealthy on health care and rewards inefficiency. Every economist has said that.

Republicans and, to their credit, our sponsors for the bill, have said that if you are going to have the delivery system in the private sector, you are going to have to have tough oversight in terms of insurance practices. So you cannot have cherry picking, just take healthy people and send sick people over to government programs more fragile than they are.

The Lewin Group has analyzed our proposal. It is the first bipartisan proposal in the Senate in 15 years for universal coverage, with Senator Bennett, Senator Gregg, Senator Bill Nelson, Senator Lamar Alexander, and myself. And obviously we want to do what Chairman Conrad has been talking about, which is use it as a starting point. This is not the last word in a piece of legislation. This is an effort to begin the debate.

We have a wonderful panel, all of whom I read your articles regularly. Dr. Aaron, really one of my heroes in the field. Probably the only area I have a difference of opinion with Dr. Aaron on is this question of having to spend a lot of money to get started. I think you know that the Lewin Group has analyzed our proposal. They believe that it is possible to get to universal coverage without significant expense in terms of the short-term and there would be savings over a 10-year period.

I think it really comes down to, as Senator Gregg touched on, a question of language. And that is one of the things I am going to

be interested in exploring with you, Dr. Aaron, is why you see something like this requiring a significant amount of additional money at the outset. I know that there are issues with respect to demand that you would have in a new program, questions of technology and the like.

We have a wonderful panel. Mr. Chairman, I think you for your thoughtfulness to be able to have this opening statement, and for your kind comments.

Chairman CONRAD. Thank you, Senator Wyden, for all the effort you have put into this subject.

I will also call on Senator Allard. Senator Allard, who has announced he will not be seeking reelection, so will be retiring at the end of this term, has been a very valuable contributor to the work of this Committee and I want to thank them for all of the time and effort he has put into the work of the Budget Committee.

Senator ALLARD.

OPENING STATEMENT OF SENATOR ALLARD

Senator ALLARD. Thank you, Mr. Chairman.

I just want to make a few brief comments, I do not have anything prepared.

I have dealt, in the State legislature of Colorado when I served there, we dealt with the uninsured. And we have continued to deal with it here in the Congress.

One of the things that I have noticed is that the percentage of people who are uninsured remain static. The number of people that are underinsured increases because you have more people. In runs around 15 or 16 percent. It is a straight line over all those years.

I think that the 15 percent or 16 percent, a lot of it has to do with mobility issues. They are—employees, for example, are going from one employer to another. And so they hit a period of time when they are not insured. It is young people, who are just entering the work place for the first time and have not really settled in about what it is they need, they kind of feel an invulnerability.

I think those are the two groups that really drive a large percentage. It is a fixed rate. And I think mobility is one of the things that we have to work on in covering. I do not think we want a government-run health care system because I think we want basically a patient-driven one. And I think the patient has to participate in the costs to a certain degree.

I can think of several corporations in Colorado who decided they were going to cover all of health care costs of their employees. And when I was in the State legislature they had to discontinue those policies because they were abused. And so you need some participation from the patient in the cost of that so that you make responsible decisions.

I do think that we need to drive this so that more people are insured. And I look forward to working with Senator Gregg and the Senator from Oregon, Senator Wyden, on this issue. I serve on the Health Committee here.

But I do think those are important things that need to be addressed and I think we can deal with that percentage with just some real thoughtfulness about how we are going to get people on the roll in a way that is not going to bankrupt his country.

If we go to a nationalized government-driven health care, the costs are horrendous. And then you have a lot of problems with spending, as far as the budget is concerned.

So I think if you really are serious about resolving this issue with the cost of health care and everything, we have to have a patient-driven system that ties the patient and the doctor closer together on the decisionmaking process, having the patient take some participation in the cost, and to deal with the mobility issues.

Thank you, Mr. Chairman.

Chairman CONRAD. Thank you, Senator Allard. Thank you very much for your contribution to the work of this Committee.

Senator Whitehouse, would you like to make a brief opening statement?

OPENING STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. I would be delighted to and I am very pleased, Mr. Chairman, that you have given all of us the opportunity to do this.

As the newest member of this Committee, I come to it with considerable regard for the work that has been done before I got here, but also with some fairly firmly held observations that I have made during the course of my professional career.

The overarching observation that I have made is that our health care system, as an administrative system, is a disaster. It is a broken system. In terms of its plumbing, it is bad plumbing. In terms of its wiring, it has been wiring. In terms of the incentive that it creates, it creates unhelpful incentives. And it is very important, because it is government's role to set the conditions for proper market conduct. And we have not done that yet.

So I think it is very important for us to be having this discussion.

I would suggest to the ranking member, my senior Senator, the Senator from New Hampshire, Senator Gregg, that for the average business or for the average family what you have to pay for health care is probably more important to you than who you have to pay it to. There may very well be circumstances in which by the government taking over at least certain parts of the system or mitigate it more closely or making higher demands of it, even in circumstances in which in order to do so you may have to raise taxes a bit, enormous savings in the overall operation of the system can result. That is a concept that I think is an important one to keep in mind as we address this problem.

I think some of the areas in which the market conditions are failing most dramatically involve the areas where improvement of the quality of the care that is delivered in the health care system and lowering the cost of health care system actually occupy the same space. Over and over again we have seen issues where in intensive care units you can reduce infections dramatically and lower the cost and save lives.

And yet it does not get done anywhere near to the optimal level, I think, because of the way the system is set up to reimburse and encourage conduct. In fact, you put people in the situation where doing the right thing causes them economic punishment. And that is just a dumb way for the government to set up a system to operate.

The other area that I am very concerned about is the wild underinvestment we have in health information technology. You can look at a couple of ways. You can look at it like the highway system. I do not think everybody begrudges Federal Government spending in the highway system. It is a common good, and it saves enormous money to our economy by having people be able to truck goods here and there and to be able to go and visit grandma in Illinois. We do not worry too much about that.

And yet, when you talk about building an information highway that would carry health information technology so that we could have more efficiency of the system, people run from that idea as if it is communist socialist medicine. It just is not. It is just good sense.

And there, I think, are multiple ways to solve the problem. We cannot just walk away from that problem.

Ultimately, I think it is a problem of system design and I think we are on a fool's errand if we believe that market failures can be cured by the market. The market failure is itself a sign that the system does not allow the market to operate in the ordinary course. So to sit back and say well, we have this market failure. But if we just wait long enough eventually the market will correct it, I think is hopeless folly.

I think there may very well be very areas of care where the security and the manageability that is provided by government oversight or management of sections of the health care system is merited. And I think there are also areas in which it is important for the innovation and choice that people expect out of a health care system to also be permitted.

So I think as we go into this discussion, it is important that we leave our options open and think about what the best way is to result with a system design that makes sense, rather than start from an ideological proposition that if it is going to raise taxes it is bad, even if it saves money overall, or to start from the proposition if the government manages any part of the health care system, that is such a bad thing we cannot even discuss it.

Thank you very much. Thank you, Mr. Chairman.

Chairman CONRAD. Senator Sanders, we have departed from our usual custom here and allowed a 3-minute opening statement. If you would like to avail yourself of that, you would be welcome.

Senator SANDERS. Reluctant as I am to publicly speak, I will take advantage.

[Laughter.]

Senator GREGG. I was assuming, Senator, that I had given your opening statement for you.

[Laughter.]

Senator SANDERS. But you did not have the charts.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much and let me pick up on Senator Whitehouse's point. Of course, I only heard half of his remarks, but we will see.

Senator WHITEHOUSE. The good half.

Senator SANDERS. The good half.

The simple truth is it is appropriate that the Budget Committee deal with health care. Why? Because we are spending an enormous amount of money.

Now some people say well, the real problem is Medicare and Medicaid. Boy, that is a lot of money. Gee, the American people love spending money on BlueCross BlueShield, General Connecticut, all the private insurance. That is not a problem. But Medicare and Medicaid and government spending, boy, that is just awful. And obviously that is just nonsense.

Nobody that I know worries about whether it is BlueCross out of their own pocket. They are spending money on health care. And the issue that we have to deal with as a Nation are two fundamental issues. As a Nation, should we guarantee health care to every man, woman, and child as a right of citizenship? Simple question.

Some people say no. If you have the money in this country, you have a big house, you have a big car, you have good health care. If you do not have the money, tough luck. That is a point of view some people hold. I disagree.

I think that health care, just like education, should be a right, r-i-g-h-t, of all of our people. In my State, most of the people agree with that. I think nationally, in fact, most people agree with that.

Then obviously, the second question is if you are going to provide health care to every man, woman, and child what is the most cost-effective way to do that? The answer is the system that we have is not only a system that is disintegrating, it is enormously wasteful, it is enormously bureaucratic. We have today 47 million Americans who have zero out the insurance, even more who are underinsured. And yet we spend twice as much per capita on health care as do the people of any other major country on earth.

Why is that? Well, among other reasons, over 30 percent of the money we spend on health care does not go to doctors. We have a doctor shortage. It does not go to nurses. It does not go to dentists. We have shortages of dentists and nurses. It goes to bureaucracy, administration, billing, advertising, all of the things we do not need.

So in my view, and I know this is a radical idea in the U.S. Senate, I think we should move toward a national health care program. I think we should guarantee health care to all people. I think it should be a publicly funded system. I think it would be infinitely more cost-effective than the wasteful and bureaucratic systems we have right now.

I just, the other day, introduced legislation with John Tierney in the House which is pretty conservative. And that is why we are looking forward Judd Gregg's support for this legislation. It is very conservative.

What it says is, not to go forward right now because politically we cannot do it with Bush in the White House and so forth. But to go forward and have 10 States promise, if they are making a commitment to do universal health care—not single-payer, what I would like, universal health care—we will provide the waivers that they need. We will provide the financial support that they need. We will use States as a laboratory. And States will go forward.

And we will learn from each State's mistakes and strengths. And then perhaps we can develop a national program. I hope that some States will go forward with a single-payer model, which I think will show that universal health care can be done cost-effectively. But we will learn from each strengths, positive and negative results, and then we can forward as a Nation.

So let me again congratulate the Chairman because it is totally appropriate for the Budget Committee to be dealing with health care. This system is broken. We need to move in a new direction. And thank you very much, Mr. Chairman.

Chairman CONRAD. I thank the Senator. And I again thank the witnesses.

We will start with Dr. Aaron, Senior Fellow at the Brookings Institution, and I think widely admired on both sides of the aisle here in the U.S. Senate.

Dr. Aaron, welcome.

STATEMENT OF HENRY J. AARON, PH.D., BRUCE AND VIRGINIA MacLAURY FELLOW, ECONOMIC STUDIES PROGRAM, THE BROOKINGS INSTITUTE

Mr. AARON. Thank you very much. I appreciate the invitation to testify this morning, and I ask for my statement be part of the record.

Chairman CONRAD. Without objection.

Mr. AARON. Yesterday, when I finished writing that, I started by saying that I thought there were three coequal health care problems: cost, quality of care, and taxes. This morning I am inclined to lament that, having just come from a physician's appointment, which took no more than 15 to 20 minutes, at the end of which I signed a credit card payment of $920. So our cost weights a little more heavily on my——

Chairman CONRAD. And you are looking very healthy this morning, as well.

Mr. AARON. That raises an important point. We are willing to pay if we get good value for money.

In my statement, I argued that there are, as you well know, alternative ways that have been proposed to advance universal coverage and reform the health care financing system, variously conservative, liberal, and incrementalist, some relying on the tax system, some involving additional reform of the insurance system, some involving a single-payer approach of one stripe or another.

The critical point, I think, to keep in mind is that any one to these approaches, well designed, implemented in a non-ideological matter, is capable of achieving significant improvements over our current system. Any one of the three, implemented in an ideologically narrow-minded manner and ineffectively, could do very serious damage to both cost and access to care.

So I think the thing to do is to try to get by the ideological differences among the various approaches and focus on the nuts and bolts of how a particular approach is done.

One point has been made that I would like to reemphasize, a point that was made during the initial statements. We sometimes focus on the budgetary problems posed over the long run by Medicare and by Medicaid. The point was made that it is impossible ef-

fectively to deal with those problems in isolation from systemwide reform. The same hospitals, the same doctors care for Medicare and Medicaid patients and for those who are insured privately. For simple psychological and professional reasons, they render approximately the same care to different patients.

If we are to reform this health care system, we have to attack it whole and not piecemeal.

Having agreed with some of the points made, I would like to raise some questions about some of the others that were made during the opening statements. Former Senator Moynihan used to say that everybody is entitled to his own opinions, but not to his own facts. The statement has been made that government health insurance is horrendously expensive. We have abundant evidence around the world that that statement is false.

The fact of the matter is that the very systems that spend, among the 10 richest OECD countries other than United States, on average half as much per capita as the United States does, all have systems that are far more government run than our own. They spend less. There are consequences from those lower expenditures, no question about that. But the idea that government-run health insurance is necessarily a budgetary catastrophe is simply untrue.

It is not even true in a narrower sense. The United States' tax burden in support of government health care spending is nearly as great as that of any other developed nation in the world. There are a couple of countries where the government costs are slightly higher than those of the United States but they are lower also in many other countries. The very fact that we support nearly enough of health care spending through public budgets and we spend, on average, twice as much as the 10 next richest countries in the OECD do means that our public burden approximates that of the government-run systems elsewhere.

So there are high taxes in Europe, no question about it, much higher than are tolerated currently here in the United States. Health care spending by the government is not the reason.

One other point I would like to make is that the emphasis on universal coverage that everybody has been making here today, I think is altogether correct but for a different reason than many people emphasize. The simple fact is we are never going to be able effectively to control the growth of health care spending until we have essentially universal coverage. Why is that? The reason is that inevitably cost control is going to mean saying no for some kinds of services. It is going to mean cutting back on expenditures in some fashion.

If some people are uninsured, providers will honor the demands of the strong payers, the well insured. The fact of the matter is that today the uninsured consume a lot of health care. And for that reason, the fact that there are a great many uninsured is not the catastrophe that it might be because they do have access to a great deal of health care.

Try to impose significant cost controls in a system where some are uninsured and you will discover that the lack of health insurance takes on a whole new meaning and not one that I think any of us would wish to contemplate.

Finally, I would like to draw on the theme that Senator Sanders made at the end and that I think Senator Feingold would make if he were here today, rather than with the rest of the world down listening to General Petraeus, or asking him questions.

That is that there is a great deal of energy currently apparent around these United States at the State level trying, at the State level, to do much of what we are talking about here this morning. That is extend coverage, hold down costs, and improve health care quality. There is a great deal that the Federal Government could do to make it easier for States to move ahead with these reforms.

As Senator Sanders said, I think it is wise for us to encourage those efforts, whatever our long-term goals for Nation action may be, because we have a lot to learn. The State of Massachusetts is now on the ground solving a host of problems that nobody anticipated when Governor Romney and a Democratic legislature enacted the Massachusetts plan. They are working together as of this moment, and let us hope that they continue to do so.

If that effort succeeds, the prospects of national health care reform will be greatly enhanced because we will have learned many things that work, solve many problems that arise, and push the whole cause forward significantly.

Finally, let me respond in advance to Senator Wyden. I do not think it is going to take a great deal more money but it is going to take some if we are going to achieve national coverage. I am aware of the Lewin and Associates estimate of your plan. I respect them as an organization. And I do not believe these particular estimates. Why?

Years ago my colleague, Charles Schulz, suggested that there is kind of political Hippocratic oath: do not be seen to do any obvious harm. I believe that motivation will operate powerfully when you come to markup. You are going to have to take care of various groups who fear that they would be injured by your proposal and who would line up against it unless they are provided significant assurances.

In the end I believe political bodies such as the U.S. Congress will honor a significant number of those requests and you will end up spending some additional money at the outset.

But I come back to the point I made earlier: spending that money is the ante into an environment in which real cost control becomes feasible for the first time as it is not feasible today in the current U.S. health care system.

[The prepared statement of Mr. Aaron follows:]

TESTIMONY BEFORE THE COMMITTEE ON THE BUDGET
UNITED STATES SENATE
11 SEPTEMBER 2007

by

Henry J. Aaron
Bruce and Virginia MacLaury Senior Fellow
The Brookings Institution[1]

America faces three equally important health care problems:

- needlessly high health care spending that is growing at unsustainably rapid rates;
- seriously sub-optimal quality of care; and
- large and growing numbers of people with inadequate insurance or none at all.

None of these problems is new. All have intensified in recent years.

Ideologically diverse proposals to deal with these problems have been on the table for years—in some cases for decades. These proposals fall broadly into three categories: conservative (mostly linked to tax incentives), liberal (mostly involving employer mandates or single-payer administration), and incremental (mostly involving extension of current programs and reinsurance).

- Each commands solid, but minority, support in Congress and among analysts. (Unfortunately, as Stuart Altman has remarked, the *status quo* seems to be everyone's second choice.)
- Each would boost *federal* spending in the short run. Some would do so in the long run as well, even if they lower *total* health care spending.
- Each holds the realistic promise over the long haul, *but only if implemented without slavish adherence to ideology*, to ameliorate all three problems—that is, to lower *total* (but probably not *federal*) health care spending, extend insurance coverage, and help boost quality of care.
- Achievement of significantly improved quality is possible under all three strategies for reforming health care payments. But extensive additional

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[1] The views expressed here are my own and do not necessarily reflect those of the trustees, officers, or other staff of the Brookings Institution.

action by government, health care providers, and patients is necessary to realize the quality potential of modern health care.

- None of the three strategies for payment reform currently commands sufficient support in Congress to win approval both in the House of Representatives and the Senate, where overcoming a filibuster would probably be necessary. None is likely to achieve the requisite support in the foreseeable future.

Meanwhile, state governors and legislators have been proposing and, in many cases, implementing numerous and diverse proposals to deal with all three problems, especially insurance coverage. The willingness of states to move ahead creates an opportunity to break the decades-long deadlock on reform of health care financing. Massachusetts and several other states have already implemented such reforms. If other states—most notably, California—move ahead with such measures, the environment for national action will become far more favorable than it is today. Strong bi-partisan Congressional support now exists to encourage these state efforts. This support is contingent on assurances that various states will try ideologically diverse approaches to see which ones work best. I urge this Committee to support such state initiatives as the best opportunity for making progress in solving the three health care problems I just described.

I. The Three Problems

If you are a business executive, labor leader, or a budget analyst (including, I suspect, most members of this committee), the most pressing problem is the relentless increase the cost of financing health care.

- Business leaders bewail the large but unpredictable increase in the cost of a major element of labor compensation. They are persuaded that the increase in health care expenses hampers their ability to compete internationally.[2]

- Labor leaders find themselves embroiled in an endless rear-guard action to prevent erosion of one of organized labor's most prized achievements—collectively-bargained, comprehensive health insurance coverage.

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[2] Economists almost unanimously disagree. They hold that the rising cost of health care for active workers comes at the expense of other elements of labor compensation and, so, has virtually no effect on product prices or competitiveness. So-called 'legacy' costs for unfunded health and pension benefits promised to retirees should be regarded as a charge against the balance sheet that reduces shareholder equity. Recent mandated changes in accounting rules embody this understanding. These legacy costs can, in extreme cases, affect companies' access to credit markets and may have some effect on competitiveness.

- And budget analysts increasingly recognize that rising health care spending is the sole source of projected federal budget deficits.[3]

The problem of rising costs is intensifying for a simple arithmetic reason. Real health care spending has been rising by about 2.7 percentage points a year more than income since about 1960. Because health care spending represents a progressively larger share of income, this excess growth takes an increasingly large bite out of income.

For many health policy analysts, the most pressing problem confronting the U.S. health care system is its failure routinely to deliver high-quality health care. An exhaustive study showed that half of all patients do not receive recommended care.[4] The Institute of Medicine finds that tens of thousands of people die annually because of needless medical error.[5] The United States lags embarrassingly and inexcusably in the adoption of electronic medical records that preserve patient confidentiality but are available to caregivers. The failure of U.S. physicians to recognize that provision of high-quality care has become a team sport, not a solo activity, exposes U.S. patients to needless risks and many to less-than-optimal care.[6] The failure to use efficiently the roughly $2.3 trillion that will be spent this year on health care is a massive lost opportunity for all Americans, including especially the insured 85 percent who think—perhaps erroneously—that they are getting the best care in the world.

The problem of sub-par quality is increasingly serious for a paradoxical reason—today's health care, at its best, can do far more than could yesterday's treatments. The staggering advances in bio-medical science mean that when providers fail now to deliver what health care has to offer, patients lose far more than they did in the past.

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3 Henry J. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem—Which is It?," *Health Affairs*, vol. 26, no. 6, November/December 2007, pp. 1-12; Peter Orszag, "Health Care and the Budget: Issues and Challenges for Reform," Testimony before the Committee on the Budget, U.S. Senate, June 21, 2007.

4 Elizabeth A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, 348 (26), June 26, 2003, pp. 2635-45.

5 Institute of Medicine, *To Err Is Human: Building a Safer Health System*, Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C., National Academy Press, 1999; *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C., National Academy Press, 2001.

6 Thomas H. Lee and James J. Mongan, *Are Healthcare's Problems Incurable? One Integrated Delivery System's Program for Transforming Its Care*, The Brookings Institution, Health Policy Issues and Options, December 2006.

And if you are an American who takes pride in your nation's values, you should share the national shame that 47 million of your fellow citizens lack insurance coverage. To be sure, not all of the uninsured lack financial access to care—some can pay for the cost of treating most illnesses themselves. To be sure, some of the uninsured are eligible for coverage under Medicaid or other programs in which they neglect to enroll. To be sure, most of the uninsured will regain coverage before too very long. But, as well, far more than 47 million risk losing coverage if they become unemployed or change jobs or if some new federal regulation forces their state to curtail coverage of the poor.

We analysts can have a fine intellectual scrum over exactly what number best describes how many Americans face the risk of being financially unprotected when ill. Is it 47 million? More? Less? I do not denigrate the importance of that debate. But I defy anyone to try to explain to a Frenchman, a Canadian, a German, a Swede, or a Brit our failure to insure everyone without experiencing the "you Americans just don't get it" incredulity about how we can be so backward in this regard. Regardless of what others may think, we all fail our fellow Americans when we allow tens of millions—and more of them every year—to face the risk of illnesses they cannot afford to treat.

I do not think that this committee needs reminding of the importance of these three problems. You are all aware of them. But it is vital to keep in mind that they are linked, that it is impossible to solve one without solving the others.

II. The Three Reform Strategies[7]

Dozens of plans to reform the U.S. health care system have been put forward in recent decades. Though superficially dissimilar, all fall into one of three broad categories distinguished by the political ideology that they embody—conservative, incrementalist, and liberal. Like most people, I have my preference on what is the best strategy. So, I am confident, do you. But my purpose today is less to argue for or against any of them than it is to suggest that

- each holds out the promise of significant progress in dealing with some or all of the three problems I have described, *provided that it is implemented in a non-doctrinaire way*;
- each has the potential to aggravate these problems if implemented in an ideologically rigid manner; and

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7 This section of my testimony draws heavily from, but extends and modifies, Henry J. Aaron and Joseph P. Newhouse, "Meeting the Dilemma of Health Care Access; Extending Insurance Coverage while Controlling Costs," *Opportunity 08: Independent Ideas for America's Next President*, Michael O'Hanlon, editor, Brookings, *forthcoming in 2007*.

- none has a prayer of being enacted in the foreseeable future.

High-Deductible Insurance

President Bush has sought to establish high-deductible health insurance as the norm for health insurance. In so doing, he has been advancing an approach long espoused by political conservatives as the most promising way to extend coverage and to control spending.

Under this approach, patients must pay directly for health care spending up to a dollar limit higher than most current insurance plans require. Beyond that limit, insurance would cover all or nearly all costs of care. Tax incentives would encourage most people to save in special health savings accounts (HSAs) to pay for most outlays below the deductible. The government would subsidize HSA deposits for low-income households. Unused balances would eventually be available for general consumption or for bequests.

Because savings would potentially be usable for purposes other than health care, advocates claim that account holders would have increased incentives to spend these dollars more carefully than they do when insurance lets them spend "other peoples' dollars." As a result, it is argued, growth of health care spending would slow. Health insurance would become more affordable than it now is. The trend toward narrowing of insurance coverage would be slowed or reversed.

The effect of such plans on spending is more complex than this simple argument suggests. Large deductibles do greatly reduce spending, compared to first-dollar coverage—perhaps by as much as 30 percent. But few people still have first-dollar coverage. So, potential savings from increased deductibles are much smaller than 30 percent. Furthermore, high-deductible insurance would raise spending by some people, notably those currently uninsured who would buy insurance because of tax incentives or reduced premiums for high-deductible insurance. The bottom line is that net savings are hard to gauge.

This approach has the potential to reduce the number of uninsured and help slow the growth of spending. Realizing that potential, however, depends on policies that comport uneasily with views commonly espoused by those who embrace market approaches to social policy. Sizeable subsidies for low-income households and aggressive regulation of insurance markets are both essential to ensure that reasonably priced plans are available to high-risk families and that low-income families can afford coverage.

Many conservatives regard aggressive regulation as antithetical to unfettered markets.[8] And they are surely right. But private insurance companies cannot be expected willingly to sell coverage for less than anticipated costs. Accordingly, regulation to assure the availability of affordable insurance is inescapable if the goal of ensuring fair access to insurance is to be realized.[9]

Furthermore, unless subsidies to low-income households shield them from nearly all out-of-pocket risk, many will not willingly buy insurance (if they must pay much of premium cost) or use ostensibly covered services (if they are exposed to significant deductibles). An individual mandate, as in Massachusetts, would be necessary to assure full coverage. But many conservatives deplore such an abridgement of individual choice.

Finally, recent research has shown that in some cases, the cost-minimizing strategy is to subsidize patients to follow recommended health care regimens, rather than to impose any cost sharing at all.[10] This finding refutes the idea that for all services, patients must have 'skin in the game' to minimize cost.

What this all means is that if the high-deductible/HSA approach to extending coverage and lowering costs is to work fairly and efficiently, it cannot be applied in a simple or ideologically pure way. Advocates must accept rather intrusive regulation and high subsidies for the sick and the poor. They must also recognize that the best way to minimize costs is not always to make patients pay something for the care they use.

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[8] Not all conservatives take this position, however. See Stuart M. Butler, *Evolving Beyond Traditional Employer-Sponsored Health Insurance*, The Brookings Institution, The Hamilton Project, Discussion Paper 2007-06, May 2007.

[9] The point can be put simply: regulation is inconsistent with unfettered market competition; but unfettered market competition sometimes produces inefficient and unfair results.

[10] The cost-minimizing strategy for treating some diseases has been shown to involve subsidies to patients to take recommended drugs. This policy increases drug use and expense, but increased drug use reduces complications and associated outlays on physicians and for hospitalization by more than the added costs of drugs and subsidies. John T. Hsu, et al. (2006), "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, 354(22): 2349-2359. Stephen B. Soumerai, et al. (1994), "Effects of Limiting Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia," *New England Journal of Medicine*, 331(10): 650-655. Stephen Soumerai, et al. (1991), "Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes," *New England Journal of Medicine*, 325(15): 1072-1077.

Incremental Change

The second strategy seeks to strengthen and extend employment-based coverage, rather than replace it. One way would be for the federal government to provide reinsurance for all health spending above some threshold. The most immediate effect of such reinsurance would be to reduce insurance premiums. It would do so by paying through taxes costs that are now paid through premiums. By reducing premiums people face, this subsidy would increase demand for insurance. In particular, this approach would decrease the cost to insurers of covering people deemed to be bad risks. It would, thereby decrease the number of uninsured.

Unless the subsidy were large, however—that is, unless the reinsurance threshold were low—the reduction in the number of uninsured would likely be modest. Approximately half of large and medium-sized establishments self-insure or buy reinsurance now. In the individual and small group markets reinsurance would reduce, but not eliminate, insurers' incentives to select against bad risks who, even with reinsurance, would remain unprofitable.

A second incremental strategy would be to authorize currently ineligible individuals, employers, or other groups to "buy in" to Medicare or to the Federal Employees Health Benefits Program (FEHBP). Premiums could be actuarially fair or subsidized. A third strategy would be to expand Medicaid eligibility—for example, to parents of currently eligible children.

The major advantage of the incremental strategy is also its principal weakness. It disrupts current arrangements least. It requires few large shifts in financing that might necessitate large tax increases, generate windfall reductions in costs for businesses, or impose large payments on individuals. For the same reasons it would do little or nothing to simplify the current crazy-quilt of financing arrangements. In addition, it would weaken the already tenuous incentives of employers to act as cost-control agents on behalf of their employees. Finally, broadening employment-based coverage by itself would do nothing to deal with the unfortunate consequence of employment-based health insurance that forces workers to change health insurance whenever they change jobs and that confronts many two-earner families with needless and complex decisions about which spouse's plan to use when both are eligible. The latter problems could be solved if federal or state governments created something akin to the 'insurance connector' which is part of the recently implemented Massachusetts plan.

Medicare-for-All

A sizable minority of Americans has long embraced the principle that a single, nationally-uniform insurance plan should cover all Americans. One current embodiment of that strategy would enroll everyone in Medicare. Each would have a single menu of benefits financed jointly by earmarked taxes and premiums. As now, Medicaid could cover

some or all premiums, cost sharing, and additional charges for low-income enrollees. Medicare beneficiaries would continue to be able to join health maintenance organizations, where available, and Medicare would pay their premiums in place of covering standard benefits.

No advocate of Medicare-for-all has fully explained how it would work. Would employers be required to pay taxes equal to some or all of what they now spend on health insurance for employees? If so, how would the taxes be designed? What charges, if any, would be imposed on employers who currently do not offer health insurance benefits? In general, how would revenues be raised to cover insurance costs? What premiums and cost sharing would people face? What relief from those charges would low-income households receive? Would supplemental insurance, which most Medicare beneficiaries now have, be folded in? Would people now eligible for Medicaid shift to Medicare?

Other variations on the 'single-national plan' approach exist and some have addressed the financing issues in some detail. All suffer from a politically challenging feature. They would shift a large part of currently privately financed costs of health care to public budgets. The apparent hesitancy about expanding the size of the federal government budget by the amounts implied in these plans will remain a formidable obstacle to their serious consideration.

Single-payer approaches that run through direct government payment for services would encounter many of the same problems that have troubled Medicare. These problems include a cumbersome system of administered prices, a lack of choice regarding benefits within the traditional program, controversy over which new services to cover, when, and at what price, and the political impossibility (at least so far) of excluding inferior providers from the program. The problem of a lack of choice can be solved if the government offers a modest number of alternative plans. The other problems might be solvable if the government was able to contract with one or more private plans that would compete to win the service contract or to attract patients. But this feature would be at odds with the single-payer approach, as critics of the Medicare prescription drug program emphasize.

III. Quality

No payment reform will suffice to close the gap between the quality of care that the U.S. system currently provides and what it is capable of providing. To achieve that goal, two additional steps are necessary:[11]

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[11] Whether they will prove *sufficient* will depend on the will of patients and of private and public payers to use evidence and change practice to cut spending—that is, to ration care.

- create an organization, backed with ample funding and independence from political influence, to evaluate currently-used and newly-developed medical procedures, drugs, and devices;

- supply assistance, through funding and regulation, to help private hospitals, physicians, and other health care providers adapt modern information technology to the delivery of health care.

Effectiveness Research

The first step is to increase the body of knowledge about which medical procedures work best and are cost effective. On several occasions in recent history, Congress has established or empowered agencies to evaluate medical technology. Unfortunately, Congress then made two key errors. First, the resources provided such agencies were never adequate to do the job well. The size of the task is enormous. Most of what physicians now do has never been adequately evaluated. Second, when these agencies tried to do their jobs and found some procedure or device dear to providers or investors ineffective or not worth the cost, those who were adversely affected quickly attacked the findings. Congress, alas, did not defend the agencies for doing the jobs they were charged to do, but instead gelded or killed them.

The stakes in money wasted on low- or no-benefit care and lives blighted by inferior care are too great for this dereliction of responsibility to continue. I urge Congress to create an agency with two key attributes.

- It should be funded adequately from sources independent of annual appropriations.

- It should be managed under rules that protect the organization from short-term political interference.

The legislative mandate should be to evaluate both currently-used and newly developed medical procedures and devices not only against placebos, but also against other available treatments, for effectiveness and cost-effectiveness. Various funding methods would suffice—a small set-aside on each dollar spent through Medicare or charges on private providers or insurers, for example. Independence of political influence would be adequate if the agency was managed under rules similar to those under which the Board of Governors of the Federal Reserve are appointed.

Rather than traveling this route, however, it appears that Congress may be repeating past errors. The House of Representatives included a provision in the recently passed SCHIP reauthorization bill to increase effectiveness research. This provision reflects admirable intentions but is, in my view, inadequate. The sum envisaged to support this activity, approximately $3 billion over ten years, according to the Congressional Budget

Office, comes to about one one-hundredth of one percent of health care spending projected over this period.[12] An initial commitment ten times as large would not suffice for this huge challenge. Furthermore, the responsibility for spending this paltry sum would rest with the Agency for Health Research and Quality, an admirable organization, but one that is politically vulnerable, as documented by its experience with previous efforts to carry out effectiveness research.

The development of a body of knowledge will not instantly transform the delivery of medical care, a point strongly emphasized by the Congressional Budget Office. But without such information, there is no way that an insurer or a government agency or business can long withstand the demands by patients and providers to cover procedures, drugs, and devices that are alleged to deliver some benefit. With such information, there is some chance.

Information Technology

The application of information technology to the delivery of health care is a means not an end. The end is replacement of the traditional view of physicians as solo, all-knowing managers of each patient's care with a new model of health care as a team activity involving many specialist providers who work together.[13] This new model is essential for high-quality care. The body of medical knowledge has become too large for any one person to master, and new information is becoming available too fast for any one person to absorb it all. Information technology is the instrument that makes such collaboration possible by making all facts and research relevant to a patient's care instantly available to all care-givers, avoiding pointless, duplicative, and lost tests, and minimizing the risk of adverse drug interactions.

The transformation of the medical culture from physician-as-all-wise-captain to physician-as-member-of-a-team is something that the medical profession itself will have to manage. But federal support of information technology, a critical input to this transformation, is important and has so far been lacking. The law creating the federal office charged with promoting information technology, headed for some time by the very capable David Brailer, explicitly stated that no new funds should be appropriated to aid its work.

IV. COVERAGE

With metronomic regularity, the United States has undergone spasms of generalized angst about the plight of the uninsured. These spasms have occurred at intervals of ten to

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[12] Peter B. Orszag, "Letter to the Honorable Pete Stark," September 5, 2007.

[13] Thomas H. Lee and James J. Mongan, *Are Healthcare's Problems Incurable? One Integrated Delivery System's Program for Transforming Its Care,* The Brookings Institution, Health Policy Issues and Options, December 2006.

fifteen years. Public opinion polls indicate general support for such reform. Presidents put forward detailed plans. Confronted with a specific plan, the U.S. political system rejects is. Why? What is going on?

Part of the reason is ideological disagreement. These disagreements remain as strong today as they were when President Franklin Roosevelt withdrew universal health insurance coverage from the Social Security Act because he feared that its inclusion would cause the whole bill to be defeated, or when President Harry S Truman could not persuade Congress even to hold hearings on his proposal for health insurance coverage. The fate of President Bill Clinton's health reform plans simply continued an old and established political tradition.

Even if these ideological divisions had narrowed—for which there is little current indication—health care reformers would still have to confront another equally formidable obstacle: arithmetic. For starters, health care reform is big. The U.S. health care system annually spends a sum equal to the combined gross domestic products of France and Spain.[14] That means that the financial and political interests in the *status quo* are vast—as vast as the entire economies of France and Spain. Second, unless health care reform greatly boosts spending—something that virtually no one considers necessary or desirable— it is zero-sum politics. That is, *health care reform is first and foremost redistribution*—redistribution from those who now receive services to those who don't; redistribution of income from providers for whose services demand will fall to those for whose services demand will increase; and redistribution of financial responsibility among individual consumers, businesses, and government (that is, taxpayers).

This latter point is particularly tricky and poorly understood. Those who write checks to pay for health care include individuals, businesses, state and local governments, and the federal government. Reform will redistribute who writes checks to pay for health care. That means that if total health care spending is unchanged—and even if it is reduced—some groups will end up paying more. In particular, a larger share of the total cost of care under most options is likely to flow through the federal government, which means taxes will probably have to go up, even if total spending goes down.

The key point is that changing financing arrangements means that some of those who provide health care will gain and a roughly equal number will lose. And while advocates of reform may claim that their really terrific plans will so greatly boost efficiency that nearly everyone will eventually gain, those efficiencies will take years to realize. Meanwhile, vast economic and political interests will lose. The identity of the losers is never apparent as long as one is debating broad principles. That is what various labor-

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[14] In 1993, my colleague, Charles Schultze, noted that the Clinton health plan would reorganize, with one bill, activities as large as the gross domestic product (GDP) of France. Since then, U.S. health care spending has outpaced French GDP.

business groups and policy elites are doing just now. And it is a major reason why a gauzy health-care-reform-is-possible-at-last euphoria seems now to be enveloping many political leaders and analysts. But the identity of losers or possible losers will snap into focus as soon as one specific proposal becomes the subject of serious debate. At that point, those who think or fear they will be losers will mobilize, along with those who disagree ideologically with the particular approach embodied in the plan. The political result, though not perhaps written in the stars, has been depressingly consistent for a very long time.

IV. The Worst Road to Reform—Except for All the Others

Although the likelihood of national health care reform of any stripe remains poor, prospects for making progress in extending health insurance coverage and reining in the growth of spending are better than they have been in decades. (And, as noted in the preceding section of this testimony, the federal government can do much to support the medical profession in improving the quality of health care services.) The reason is that state governors and legislators are responding to the widespread concern about a lack of coverage for many and rising costs for all.

- The Massachusetts plan is the most widely known. It mandates that every individual have insurance or pay a tax penalty, provides subsidies to members of low- and moderate-income families to help them buy it, and creates a state-run agency that enables individuals and employees of small businesses to buy insurance through a large pool at community-wide rates.

No other state has implemented so sweeping a plan, but some have them on the drawing boards, and many are moving aggressively to extend coverage.

- Maine's governor has proposed to implement an individual mandate, as in Massachusetts.

- Illinois has implemented a program to offer insurance to all children under Medicaid or SCHIP with a sliding premium scale. The governor has also proposed to make insurance available to all residents and free of charge to low-income residents.

- Pennsylvania has instituted a Cover All Kids program that provides insurance at no cost to children in families with incomes below 200 percent of poverty, at a sliding-scale premium to those from families with incomes below 300 percent of poverty, and at pooled cost to all other children.

- Tennessee has converted SCHIP into a CoverKids program that is available to all children from families with incomes below 250 percent of poverty, a CoverTN program to offer portable and affordable insurance to small business and

their employees, and a high-risk pool for people who have been turned down by insurance companies.

- Arizona's governor Napolitano proposed to extend SCHIP to children from families with incomes below 300 percent of official poverty thresholds.

- California's governor Schwarzenegger has proposed a plan to provide universal coverage free to low-income adults and children financed by a combination of payroll taxes and surcharges levied on physicians and hospitals. Like Massachusetts, the California plan would establish an agency to create a pool for individuals and small businesses.

- Connecticut's governor has proposed a plan that would make health insurance available free of charge to low-income residents and at a premium of no more than $250 per month per person to all residents.

- New York's governor has proposed to extend free or subsidized health coverage to all children from families with incomes below four times official poverty thresholds.

This listing, although extensive and impressive, is only a partial enumeration of state initiatives to extend coverage, improve quality, and hold down spending. It excludes several states seeking to cover additional children through the SCHIP program by raising income eligibility thresholds.

Federal legislation could encourage these efforts. Three bills, all with bi-partisan sponsorship and co-sponsorship, have been introduced to provide such encouragement—two bills in the Senate (cosponsored by by Senators Jeff Bingaman [Democrat of New Mexico] and George Voinovich [Republican of Ohio] and by Senator Russ Feingold [Democrat of Wisconsin] and Sen. Lindsey Graham [Republican of South Carolina]. The House bill (cosponsored by Representatives Tammy Baldwin [Democrat of Wisconsin] and Tom Price [Republican of Georgia], has seventy co-sponsors, thirty-nine Democrats and thirty-one Republicans. This is the kind of bi-partisan support that is vital to the success of health care legislation.

Although the bills differ in important respects, all would establish, under federal sponsorship, a bi-partisan commission to vet and recommend to Congress state plans to reduce the proportion of state residents who are uninsured. States would have to set specific targets and their performance would be evaluated on whether they met those targets. States would be encouraged to use any of a wide range of instruments to extend coverage. These instruments would include ones commonly espoused by both conservatives and liberals—such as health savings accounts, SCHIP expansions, enrollment in the Federal Employees Benefit Plan, and single-payer reforms. Commission rules would be structured so that an ideologically diverse menu of plans would be approved. These plans

could include waivers of some current regulations to permit funds to be combined in imaginative ways.

The bills differ in whether additional funding would explicitly be provided to the states whose plans were approved. I believe that additional funding, as called for in the Feingold-Graham bill, will be necessary for two reasons.

- Any reform that extends insurance coverage will at first boost total health care spending. The currently uninsured on the average consume less care than do the insured. States should assuredly shoulder part of this added cost. But, for obvious reasons, some federal support for the added costs of coverage will encourage states to move on what is a national as well as a state goal.

- The greatest risk to *sustained* state support for extended health insurance coverage is the business cycle. During recessions, states must cut back spending. Recession would likely force states to renege on commitments to support insurance coverage. For that reason, some form of counter-cyclical back-up for state plans is essential if the commitments to expand insurance coverage are to be sustained.

Thus, a sort of syllogism argues that the most promising avenue for extending health insurance coverage, limiting growth of spending, and improving the quality of care lies in action by the states, abetted by federal legislation and regulation that will encourage this state action.

The premises of the syllogism are straightforward:

1. Effective actions to extend (universalize?) health insurance coverage, control growth of health care spending, and improve health care quality are critically important.

2. Federal legislation to achieve these goals is highly improbable in the foreseeable future because of political gridlock.

3. This gridlock arises not only from ideological disagreement, but also from large differences in objective conditions across the United States that no federal legislation can quickly override.

4. Many states are willing to undertake actions to achieve, in varying degrees, the three goals listed above.

The conclusion follows directly: Members of Congress can do more to reform the U.S. health care system by encouraging the states to carry through with plans they are clearly anxious to implement than in any other way.

Some analysts believe that action by the states would make eventual national action more difficult even than it already is by creating diverse entrenched interests in the various states. I believe that this view is profoundly mistaken for two reasons.

The first is that we have much to learn about how to make universal coverage work. This is the most important single lesson resulting from the efforts now underway in Massachusetts to implement its universal coverage plan. They are encountering problems no one foresaw. So far, at least, member of both parties and diverse interests are working together to solve them. If they, and other states, succeed, they will teach the nation invaluable substantive and political lessons necessary for eventual nationwide action.

The second reason is that success in a number of states in extending coverage in practical and affordable ways will transform the political dynamic throughout the rest of the United States. How different the debate in Washington would be today if the Massachusetts plan were fully operational, if it were joined by a version of what Governor Schwarzengger has proposed in California, if all children were covered under a sliding fee scale as Governor Blagojevich has proposed in Illinois, and if Governor Baldacci had successfully modified Maine's Dirigo plan so that it worked as originally intended. We would be focusing on the fact that extending coverage is feasible, not bewailing that narrowing coverage seems the nation's fate. So, I encourage members of Congress to get the process started in the only way that is currently feasible—by encouraging the states in their obvious desire to move.

Chairman CONRAD. Thank you, Dr. Aaron.

Now we will turn to Dr. Sherry Glied, the Department Chair and Professor of Health Policy and Management at Columbia University School of Public Health. Welcome.

STATEMENT OF SHERRY A. GLIED, Ph.D., DEPARTMENT CHAIR, HEALTH POLICY AND MANAGEMENT, PROFESSOR OF HEALTH POLICY AND MANAGEMENT, MAILMAN SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY

Ms. GLIED. Thank you. Thank you, Chairman Conrad, Ranking Member Senator Gregg, members of the Committee, for this opportunity to testify.

You have copies of my testimony, so I am going to focus my remarks today on the three strategies that you have put forward.

Let me start with Medicare for all, because it is most familiar.

Medicare has three important virtues that come about because it is a single-payer style plan. Everyone would be insured through the same financing, which means that we would pool healthier and sicker people together. Medicare could drive hard bargains with providers. That is the bane of our health care system today. We just pay very high prices for everything. And finally, coverage under Medicare is nearly automatically. Those are very important virtues.

But Medicare also some serious flaws, and I am going to talk about some that are a little different than have been mentioned here already today.

The Medicare benefit package was designed in 1964. We should all be very grateful to the Congressmen and Senators who did the heavy lifting at that time. But they were legislators and not fortune tellers. Health care has changed and the state of art of benefit design has changed a lot since Medicare was passed. Medicare has not kept up.

For example, health plans today never separate inpatient hospitalization insurance from physician insurance. But that was typical when Medicare was passed and Medicare still has it.

Plans today typically do not include a mental health benefit with a 50 percent co-pay. But Medicare was designed in an era of Freudian psychoanalysis, not Prozac. So we have a plan that is somewhat outdated even in its design.

Another problem with universal Medicare would be the enormous size of the program. This huge program would create tremendously powerful incentives for providers and we know that providers will organize their practices around those incentives. That would be fine. It would even be desirable if we knew how to design perfect payment incentives. But we do not. So in humility, we should design a system that is not so monolithic where we can make mistakes and make changes over time.

Moreover, the response to the strong incentives created by this single payment system will generate a system that is committed to the preservation of the status quo. Provider and beneficiary resistance to change is the reason that Medicare itself has not evolved much over 40 years. We need a system that will continue to transform itself as medical care transforms itself.

So what about an employer mandate? I have grave misgivings about extending the reach of employer coverage through a mandate. For full-time middle income workers employed in medium and large firms, job-based coverage in the United States is great. That group, with their families, constitute about half of all Americans under 65.

But that great system breaks down when you try to stretch it to cover people who do not naturally belong to it such as part-time workers, people who change jobs frequently, low-wage workers, workers in small firms. It just does not make any sense to force this group to get their coverage through their jobs. And if employers cannot play, an employer mandate becomes nothing more than a disguised payroll tax on low-wage workers who work for small firms.

The third option under consideration is an individual mandate combined with a fair subsidy program. I really emphasize that because I think going forward with an individual mandate that is not combined with an appropriate subsidy would not be a reform. It would simply be cruelty.

An individual mandate can be a useful tool but I think it is sometimes seen as a sort of panacea that will solve all of our problems with a wave of the wand. Many of the people who would be affected by a mandate do not now have a natural place in which to buy coverage. They do not have a place to bargain with providers, they are on their own, or to pool risks.

This problem can be addressed by creating new purchasing pools but there will always be a tendency to allow those pools to compete with one another or to allow participation in the pools to be voluntary, to allow people to decide whether they want to be the pools or to stick with their employer coverage. If that happens, the pools will fall apart and the system itself will deteriorate. We have seen it happen before. Indeed, even existing employer group coverage could evaporate in that environment.

An individual mandate also faces enormous administrative challenges. Enforcing the mandate on people who spend three or 4 months uninsured, which is a very typical pattern as I think you have pointed out, would be very difficult, much moreso here than say in the Netherlands or Switzerland where they have individual mandates but in an atmosphere of far less labor mobility, with a much higher base rate of health insurance coverage, and much more intrusive kind of state.

In my view, the best designs for health care reform actually combine elements of all three of these options, although I think, as Henry Aaron pointed out, that any one of these could be an improvement over the present mess.

At the same time I have some bad news, I think. None of these solutions, no possible combination of them that you might come up with or that any of us could come up with, will actually solve the health care problem once and for all. When you look around the world at legislators in countries that have had universal health insurance for 100 years, you see them holding hearings just like this one here today.

Much as I am sure you would like to put the health care problem behind you, one forecast I am comparable in making is that 50 years from now somebody like you will be sitting there listening to somebody like me talking about health care reform.

[Laughter.]

Chairman CONRAD. That is the end of the hearing.

[Laughter.]

Ms. GLIED. So we do not have to fix it once and for all. We just have to make a step forward and realize that we are going to keep tinkering with it as we move on.

[The prepared statement of Ms. Glied follows:]

TESTIMONY BEFORE THE COMMITTEE ON THE BUDGET
UNITED STATES SENATE

September 11, 2007

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Professor and Chair
Department of Health Policy and Management
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Thank you, Chairman Conrad, Ranking Member Gregg, and Members of the Committee for this invitation to testify before you. My name is Sherry Glied. I am a health care economist and serve as the Chair of the Department of Health Policy and Management at Columbia University's Mailman School of Public Health in Columbia University. I have studied health care reform issues for the past 15 years and greatly appreciate the opportunity to share my thoughts with you today.

The urgent need for health care reform in the United States today stems from five failings of our health care system.

First, and far and away most important, some 47 million Americans lack health insurance. Lack of coverage means that people do not get valuable preventive care, that their health deteriorates, and that they face financial crises. More than that, without health insurance, the pain, suffering, and fear that all of us face when we are ill or hurt is compounded by the indignity of being forced to beg or borrow or forego solace that is readily available to the rest of us. The idea that American citizens regularly experience this indignity – whether because of poverty, ignorance, or even incaution -- is simply shameful. We deserve a health care system that provides coverage to all Americans.

Second, even among the insured, the technical quality of care is not nearly what it should be. The inadequate quality of our care shows up in one comparative study after another – our system doesn't do as well as it should and could in terms of the processes of care and, in consequence, we do not live for as long or in as good health as we should and could.

The poor performance of our health care system in all of these studies stands in sharp contrast to our perception that America has the best health care in the world. And it is true that our very best hospitals and doctors offer services that are unparalleled. But these state-of-the-art practices are isolated pockets in a sea of mediocrity. Patients discharged from these exceptional settings typically return to the weakly coordinated, poorly managed system that is our norm. Some of the excellence of the best in our system does trickle down, but it does so slowly and unsystematically.

Third, our health care system performs poorly in providing patients with quality service. In this era of 24-hour internet banking, TV screens at every airliner seat, and drive-through everything, nearly 1/3 of American doctors don't offer ANY weekend or evening hours[1]. If their patients want to see them, even for a regular health maintenance appointment, they have to take time off work. And when they get to the doctor, American patients – the same people who can now check out their own groceries to avoid standing in line – typically spend nearly half an hour just waiting until the doctor sees them. In some cities, the average patient routinely waits as long as 45 minutes. Few Americans have a copy of their own health record, virtually none of them in a form they can understand. One of the most common complaints among people enrolled in high deductible health savings accounts plans is that they can't even comprehend their health care bill. We need a health care system that offers Americans at least the level of service they routinely expect in other sectors.

Fourth, our health care system fails to protect people from the financial consequences of illness, the principal function of health insurance. Even among insured Americans, getting sick takes a substantial financial toll. Illness means days lost from work, for both patients and family members; it means additional expenses incurred for transportation, food, care-giving, health-related appliances, and so on; it can even mean the permanent or temporary loss of a job. Many Americans just do not maintain a sufficient cushion of savings to withstand the unanticipated shocks to income and spending that come with illness, even when they have adequate health insurance. If their health plan fails to cover some medical expenses, or their co-payments and deductibles are too high for them to manage, financial disaster is likely to be imminent. That failure can be financially devastating in itself – for patients, families, and creditors too. We need a health care system that protects people from the financial consequences of ill health.

Fifth, this system, which leaves out so many and offers inadequate service to the rest, is also shockingly expensive. Governments already pay for about half of our health care spending, and the other half comes from private sources. Even so, government spending per person on health care in the United States is as high as total spending per person in several other major OECD countries![2] It's almost as if half of our health care spending bought us nothing at all.

Our health care system is so expensive not because it's better than other systems, not because we use more services than people in other places, not even because we get those services quicker than people in other places. It's expensive because we pay more for the same – and sometimes worse – quantity, quality, and timeliness of services as exists in other countries with better functioning systems. We need a health care system that is affordable – today and fifty years from now – and that gives us value for our money.

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[1] Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Jordon Peugh, and Kinga Zapert. On The Front Lines Of Care: Primary Care Doctors' Office Systems, Experiences, And Views In Seven Countries. *Health Affairs*, November/December 2006; 25(6): w555-w571.

[2] Tabulations of SourceOECD. Public costs per capita in the US exceed or are about the same as total costs per capita in Denmark, Finland, Greece, Ireland, Italy, New Zealand, Portugal, Spain, Sweden, and the UK.

None of these failings come about because of venality or malice. The men and women who work in our health care system – even in our insurance companies -- are, by and large, exceptionally bright, dedicated, and hard-working. This is a systems problem, and so, Members of the Committee, it falls into your court.

NEW DIRECTIONS

You have asked me to comment on three possible directions for moving forward with health care reform: Medicare for all, an employer mandate, and an individual mandate. I'm going to address these in turn.

I want to preface my remarks by noting that, in my view, any of these options would be an improvement over the present mess. At the same time, not one of them does or could represent a comprehensive, all encompassing solution to the five problems I've described above.

That's not surprising. When you look around the world at health care systems that have existed for half a century or more, you see your counterparts – legislators the world over – endlessly tinkering with the systems, modifying them, introducing new elements and withdrawing old ones. Much as I am sure you would like to put the health care problem behind you, the one forecast I am comfortable making is that someone like me will be sitting here talking to someone like you about these same problem 50 years from now. So let's consider the options on the table today as foundations on which we will build a system into the future.

Medicare for All

Let me begin with the general notion of "Medicare for All". The very best thing about this plan is that it builds on something that already exists. Although Medicare has many serious flaws, it may be easier to bear the ills we have than flying off to others.

Medicare has three other important virtues that come about because it is a "single payer" type plan. First, everyone would be insured through the same financing, which means that healthier and sicker people would be forced into the same pool. The system wouldn't waste resources, and deny people appropriate coverage, in trying to sort people between these groups.

Second, as a single payer, the Medicare program would have tremendous clout to drive hard bargains with health care providers. Since high prices are the main contributor to high health care costs in the United States, this capacity to bargain hard is very important and Medicare for all would do it better than any other plan could.

Third, coverage under Medicare – at least under part A-- is automatic. It's the same for everyone and everyone is entitled to it.

But Medicare also has some serious flaws as a base for universal coverage. These fall into three categories: benefit design, financing design, and organizational design.

The Medicare benefit package was designed in 1964. We should all be very grateful to the wise legislators of the 88th Congress who did the heavy lifting at that time. But they were legislators and not fortune tellers. In 1964, the Surgeon General had just released the landmark report on cigarette smoking and health. The Framingham study, the big longitudinal study which identified the main heart disease risk factors, had just released its first major findings. Of the top ten procedures that Medicare beneficiaries underwent in 2003, only 3 were in routine medical use in 1964 and the majority had not yet been developed. Average length of stay in a hospital for those 65 and over was 12.6 days – it's about 5.6 days today.

No policy wonk, in his or her wildest imagination, would dream up the Medicare benefit design today. The state of the art of benefit design has evolved, but Medicare has not evolved along with it. Today, plans don't separate the insurance for inpatient hospitalizations from that for physicians – but Medicare was written before there was such a thing as outpatient surgical and diagnostic centers. Today, plans don't usually include a mental health benefit with a 50% co pay – but Medicare was written in the era of Freudian psychoanalysis, not SSRIs and short-course cognitive behavioral therapy. And no one could possibly invent the Medicare cost-sharing design today – but Medicare was written fifteen years before the RAND health insurance experiment taught us about efficient cost-sharing design.

The second feature of Medicare that makes it an awkward fit for universal coverage is the financing. Medicare operates by drawing a great deal of the money in to the Federal government, in a variety of ways, and then dispersing it. A big chunk of Medicare's financing comes from a payroll tax that is supposed to fund a trust fund to provide today's contributors with benefits in the future (not that it actually does). Many economists worry about the labor market impacts associated with a big expansion of the payroll tax to pay for an insurance expansion. Another chunk of Medicare's financing is deducted from people's social security checks to pay the part B premium. There is no comparable way to collect the same funds from working-age people. Retrofitting Medicare to the under-65 population would be more complicated than it sounds.

The third feature of Medicare that could pose difficulties is its organizational design. Medicare already pays for care for over 42 million people. That makes it among the largest health insurance programs in the world. By contrast, for example, the largest single payer program in Canada, the one that is operated by the province of Ontario, serves only 12 million people.

The enormous potential size of a universal Medicare program creates two related risks. First, a single financing program of this type creates a set of tremendously powerful incentives for health care providers. As we have learned throughout the history of the program, providers will organize their practice patterns, consciously or unconsciously, around the incentives provided by the financing system. A single financing system, in

which all money flows in the same way, necessarily creates stronger incentives than a mixed payment system. That would be fine, even desirable, if we were all knowing and could design a perfect payment system. But we can't and so we should approach this problem with some humility, designing a system that allows for some variation and experimentation.

Second, the response to those same incentives generates a system that is institutionally and organizationally committed to the preservation of the status quo. The reason that the design of the Medicare program hasn't evolved over the past 40 years is that over the past forty years all the players in the system have adapted to it, so that it is against their interest to let it change. We need to design a system that will generate creative destruction, transforming itself over time as new technologies transform the delivery of medical care itself.

Employer Mandate

What about an employer mandate? While I may be the only existing fan of the employer-based health insurance system, I have grave misgivings about extending its reach through a mandate. Employer-based coverage has existed for about 80 years, pooling risks for individuals over time and across groups, with remarkably little government interference. Indeed, nearly half of all those covered by employer-based insurance are in self-insured plans, which, because of ERISA, operate virtually without any substantive regulation whatsoever. These plans are innovative, flexible, and efficient. Benefits change with the times; new strategies for cost containment are adopted and abandoned; and, when they're allowed to do it, as in the mid-1990s, private employer-based plans can have nearly as much bargaining clout as a single payer plan. For full-time, middle income, working people employed by all but very small firms, and for their households, job-based coverage is a great system. That group constitutes about ½ of all Americans under 65. And despite all the rhetoric about the sky falling, rates of private employer-sponsored coverage for have barely budged over the past twenty years. In 1987, 66% of Americans under 65 held private insurance under an employer-based policy. In 2006, the figure was 63%[3].

The problem with an employer mandate comes when you try to stretch that very effective system to cover people who don't naturally belong to it. That includes part-time workers, workers who change jobs frequently, low wage workers, and workers in small firms. They're the ones whose job-based coverage has been eroding most. Unfortunately, just describing the category illustrates the problems with an employer pay-or-play mandate. It doesn't make sense to force part-time workers, multiple job holders, or workers in small unstable firms to get their coverage through their jobs. Often they and their job will have gone their separate ways before the coverage even becomes effective. If so, an employer mandate becomes nothing more than a disguised payroll tax on low wage workers in small firms.

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[3] Sherry Glied. The Employer-Based Health Insurance System: Mistake or Cornerstone? In Policy Challenges in Modern Healthcare, ed. Mechanic, Rogut, Colby, and Knickman. NJ: Rutgers University Press, 2005 and Current Population Survey.

Individual Mandate

The third option is an individual mandate. I am going to assume that when we talk about an individual mandate, we are talking about an option that includes enough financing to ensure that everyone can afford to buy a reasonably generous health insurance package. Requiring people to buy coverage without putting that kind of subsidy program in place would be adding injury, in the form of penalties, to the insult that people already experience by being uninsured.

With that adequate subsidy element in place, an individual mandate can be a useful tool. It can help persuade people of the importance of obtaining coverage and give them the resources to do it, addressing the problems of poverty, procrastination, and incaution that contribute to lack of insurance. It can force people to make their priorities –in terms of buying health insurance or using their resources in other ways – conform to national priorities. It allows universal health insurance to be financed without requiring the flow of substantially more funds through the Federal government. But an individual mandate isn't a panacea.

Many of the people who do not have coverage now don't have a natural place to obtain coverage. They have no natural way to bargain with providers and obtain good prices and, they have no natural way to pool their risks with others, especially if they've already had health problems. One way to address this problem is to set up group purchasing arrangements – call them coalitions, alliances, connectors, helpers or whatever.

A temptation in doing this is to allow for voluntary participation in these organizations, or to allow them to compete with one another, or to allow voluntary organizations to serve as groups. Unfortunately, history suggests that any such voluntary scheme is unlikely to work. In fact, voluntary fraternal organizations offering health insurance did exist in the United States for a brief period in the early part of the 20th century, but they failed rapidly, for just the reasons we can expect voluntary groups to fail today. It's too easy for people to join a group – a fraternal organization, church, or alliance – and to leave that group –on the basis of their own health status and the prices offered by the group. Voluntary groups can even crowd out employer sponsored coverage by drawing the best risks out of the job-based group. Ultimately, under voluntary pooling, like will sort with like, and pooling will evaporate.

To work well, an individual mandate has to compel participation in defined and pre-specified purchasing groups and those groups need to be able to take active steps, such as risk adjustment, to ensure the viability of the plans that participate in them. In my view, it should also operate so as to minimize disruption of the existing employer-based system, which already contains viable purchasing pools. To do that, people should be permitted to use income-related subsidies to buy coverage and meet the requirements of the mandate through their employers' plans.

An individual mandate also faces profound administrative challenges. Individual mandates currently operate in two countries: the Netherlands and Switzerland. These countries offer valuable lessons, but care needs to be taken in the translation. Even the Netherlands, which is twice the size of Switzerland, has a population smaller than that of the New York City metropolitan area. Both countries share a tradition of a more intrusive state than we are used to here. Each also operates their health insurance programs in ways that make it easier to enforce the mandate. For example, in both countries, all coverage runs over a calendar year, so that a check of insurer records in January reflects all new policies.

The need for taking appropriate steps to monitor and administer a mandate becomes even clearer when you look at a profile of uninsured people in the US today. An individual mandate would be relatively easy to manage for the 55% of uninsured spells that last for at least a year or more. But the individual mandate would be harder to operate for those people who spend only brief periods uninsured. About 45% of episodes of uninsurance last fewer than five months – yet illness and accident don't always wait for coverage to start again. An individual mandate needs to be designed in conjunction with a system that addresses these transitions.

WHERE TO GO FROM HERE

In my view, the best design for a health care system would combine elements of all three of these options. It would incorporate the automatic coverage element of the Medicare program, so that people who faced unexpected crises or had difficulties in managing their lives, could be assured of coverage. It would incorporate an individual mandate so that people who can afford it would purchase coverage for themselves and their families. And it would allow employer-based coverage to continue to operate where that system is most effective.

There are many possible ways to combine these elements and I don't have a favorite. The key will be to maintain both a focus on flexibility and effective bargaining power -- to deal with the changing health care system and the strength of providers -- and an affordable, accessible, compassionate system to deal with the needs of everyday Americans.

Chairman CONRAD. All right. That is more hopeful. That sounds better.

[Laughter.]

Chairman CONRAD. Next we will turn to Janet Trautwein, the Executive Vice President and CEO of the National Association of Health Underwriters.

I hope I am pronouncing your name correctly.

Ms. TRAUTWEIN. You got it perfectly. Thank you.

Chairman CONRAD. Thank you. Welcome.

STATEMENT OF JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Ms. TRAUTWEIN. Thank you. I am very pleased to be here today.

I think, as panelists, we all have run into each other many times before and we know each other. And we all really want to do the right thing. We don't always agree on all the details but I think one thing that each of us would agree on at this table is that we have to be very careful as to how we move forward, and that if we move forward for the wrong reasons or in the wrong way that we could actually end up with a worse situation than we already have.

So I would like to delve right into again addressing the three issues that we talked about. I will try to talk about a different angle than what we have already addressed so as not to be boring here.

First of all, let me start first with an employer mandate. Our members work with consumers, both individuals and employers, every single day to purchase coverage, to use the coverage that they purchase and, to make the whole thing work appropriately. One of our biggest observations, although we have members that work with all sorts of people, is that employer-based coverage does, in fact, work pretty well. It is efficient—and this doesn't imply that the individual market is inferior. What it means is that it is an efficient process.

And what it does that makes it work well is that it naturally groups people together. It controls the flow in and out of a plan, which is very, very important in controlling costs over time. And very important, it provides an easy vehicle for employers to subsidize the cost of coverage.

Now having said that, providing health insurance by employers is very, very expensive for them and they do it for a really important reason. I think that most of them want to do it for a very important reason. And that is to attract and retain the best employees. Even the smallest employers have that need and want to do that.

We are concerned about an employer mandate for either a certain type of health insurance, to provide health insurance at all, or to pay for a specified percentage of the cost.

Health insurance in this country has historically not been a right associated with employment and there are questions about whether it should be a right at all. I would like to move back to that in a moment but I want to talk just for a moment about the employment aspect.

The ability of employers to offer or not offer coverage helps businesses compete in the way that's most appropriate for that particular business, that particular business. Sometimes they can offer coverage and at other times they cannot.

This does affect our economy in this country and I think we need to be very careful as to what burdens we put on employers and be very careful to do it in a way in that we do not do harm because our economy is very important to driving everything this country, as we all know.

The other thing that we do have a problem with related to employer mandate proposals is the whole idea of play or pay or pay or play or however we want to talk about it.

We are concerned for the same reasons that Dr. Glied has said, about this tax on low-wage workers. We are concerned that, in fact, these proposals can escalate over time and that we would end up with something that we did not start with.

Our other concern is that this whole idea of opting out often puts someone into a true government-run program and that, in fact, other countries' experiences with government-run programs have shown to produce certain situations that almost always happen. And what I want to talk about is something that we have not mentioned before. It is not that it happens, it is why it happens.

The reason why it happens is that in any sort of a government-run program, regardless of how you style it, you have to deal with a global budget. In fact, wouldn't it be fiscally imprudent not to have a budget? We are the Budget Committee here. You have to have a budget on any sort of health plan.

And countries that run into problems do so because their global budgeting requires them to cut back somewhere. Sometimes it is rationing care for people of certain ages. Sometimes it is waiting lists. Oftentimes it is paying their providers a ridiculously low amount of money. It is often the providers that are cut back significantly.

In fact, we have tried this a bit in Maine through their DirigoChoice program. I know that we hear about Dirigo up here sometimes, but the fact is that Dirigo is not doing very well in Maine. And there are some very important reasons why that is the case because, in fact, even with the government running part of this program, it has cost much more than they thought it was going to. And so I think again we have to just take caution in moving forward.

Also, I do want to speak at this point about Medicare for all. Under all of the proposals that we have seen, all Americans would have access to the Medicare program as we know it. Some of them also include an option for the participation in the Federal Employee Health Benefit Program. I have looked at several different cost projections for this proposal and they are all quite high. And I agree that we are spending a lot of money today but I think we need to be careful as to how we spend it.

We have looked very carefully at this issue because our current Medicare program is a government-run program. Yet, we do not have rationing. We do not have significant waiting areas. And our seniors currently do have access to technology. But the United States is very large. When we add in all of the people in this coun-

try and we talk about the whole global budgeting process, we know that a global budget would be an absolute necessity, a necessity, with an expansion to everyone like that.

We would be forced to do the same thing that the other countries do or we would not be able to pay for it. We do not have an unlimited checkbook here. So I think that we need to the very careful about expansions and consider them carefully in the way that we do them so that we do not end up with something that we did not bargain for.

The other thing I want to talk about is an individual mandate proposal. We find the idea of individual mandates really kind of an interesting proposal. And Massachusetts, as you all probably know, became the first State to enact an individual mandate in 2006. Certainly it is an outside the box approach. But again I think the Devil is in the details. We just have to be careful as to how we might implement something like that.

There are a number of questions that would have to be addressed, particularly how the regulatory environment would have to be adjusted, particularly in the individual market. Would you couple it with a purchasing pool or a connector or an alliance or something like that? How would you make an individual mandate work?

Would it really reduce the cost of providing health care? Remember that health care is what drives the cost of health insurance. Because if we look at Massachusetts as our example, and they have not been doing it very long, they still have some of the highest health insurance premiums in the country. And so I think we need to make sure that we do not assume that there is some magic silver bullet. There is not. This is a problem that we are going to have to address very carefully.

And then beyond that I just want to mention, relative to an individual mandate, one other consideration. And please do not construe this as opposition. These are questions and we have to answer these questions. We should think about these things.

Would this really lower the number of uninsured people in the country? The easiest thing to look at, of course, is the mandate for auto insurance. In spite of the fact that we have an individual mandate for auto insurance in 46 States and the District of Columbia, the Insurance Research Council released data in June of 2006 indicating that 14.6 percent of American motorists lacked car insurance in 2004. And that 14.6 percent sounds very similar to the 16 percent uninsured that we have right now. So we have just got to figure out how, in fact, we would enforce that sort of thing.

So I would just conclude by saying that I agree that we are going to be talking about this for a long time. That does not mean that we cannot make a lot of progress in the meantime.

We look forward to working with the Committee on solutions to make that happen.

[The prepared statement of Ms. Trautwein follows:]

The United States Senate
Budget Committee

Health Care and the Budget: Options for Achieving Universal Health Coverage

September 11, 2007

Submitted by

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September 11, 2007

Good morning, Mr. Chairman and distinguished members of the committee. I'm pleased to be here today on behalf of The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists from all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the most out of the benefits they have purchased. NAHU is extremely concerned about the problem of the uninsured and how rising health care costs are impacting health insurance coverage in this country.

A great deal of national attention has been directed at finding a universal means of covering Americans' health care needs. As the cost of providing health care has skyrocketed, the cost of providing health insurance has also continued to rise. In 2006, health care spending in the United States exceeded $2 trillion and accounted for 15.9 percent of the Gross Domestic Product. These cost increases have had a serious impact on the employer-provided health insurance market, which is currently where most insured Americans obtain their coverage. Because health insurance costs for employers continually outpace the rate of inflation and employer-sponsored coverage has decreased in recent years, some advocates of universal coverage are looking at options that would eventually change the current focus away from employer-sponsored health insurance. Some who favor this approach suggest that, to be most effective, personal responsibility for being insured should be enforced through an individual mandate for the purchase of health insurance coverage. In contrast, others have suggested that the problem of the uninsured would be largely alleviated if all employers were required to provide coverage to all of their employees.

Employer Mandates

I would like to begin today with a discussion of proposed employer mandates for the purchase of health insurance. The most efficient and cost-effective way to provide health insurance coverage today is through the employer. This is not meant to imply that individual market coverage is inferior, but employer-sponsored coverage has a significant advantage in that it allows a natural

grouping of covered persons that allows for greater risk spreading, and it additionally controls the flow of people in and out of a plan, which keeps the cost of coverage lower. Group coverage ensures millions of people access to quality health insurance products, it reliably pays for those products, and results in many more insureds than if individuals were expected to apply separately. Finally, it provides an excellent vehicle for employer subsidization of the cost of coverage.

Providing health insurance for employees is an expensive endeavor but employers continue to offer it for a very important reason: to attract and retain the best employees. Their ability to do this fuels economic growth in many areas. Although many employers provide coverage, not all of them are able to do so and still keep their businesses intact. Those that do continue to offer coverage often struggle to provide health insurance benefits to employees as the cost of coverage continues to increase each year and must be balanced with needed job growth and increased pay for those already employed. Numerous studies have indicated that an employer mandate for health care expenditures will have a negative impact on wages, job creation and general economic growth. [1]

Enacting legislation that mandates employers to provide health insurance sets a dangerous precedent. Health insurance in this country has historically never been a right associated with employment, but instead has always been voluntarily provided by many employers as a benefit. The ability to offer, or to not offer, health insurance coverage and other employee benefits helps our nation's businesses attract the best workers, motivate and reward their existing employees, and compete with one another. Legislation that would make health insurance coverage an employment right, rather than an employee benefit, would hinder business-to-business competition, thereby driving prices up and the quality of services and products down for all Americans.

[1] A recent one was issued by the Employment Policies Institute in January of 2006. The study, conducted by Katherine Baicker, a member of the President's Council of Economic Advisers, and Helen Levy of the University of Michigan, found that if a typical employer mandate proposal was broadened to apply nation-wide, 45 percent of employees without insurance would see no increase in coverage. Instead, the mandate would cause job loss for over 315,000 Americans, and would principally impact low-skilled employees, since employers would be forced to cut jobs to control skyrocketing labor costs.

No matter what form an employer mandate takes, it always has the potential to harm American businesses and employees. Legislation specifically targeting our nation's largest companies may change its scope along the way to encompass smaller employers, impacting their ability to stay in business in the future. Measures that would force employers to spend certain dollar amounts or percentages of their payroll on health care costs merely provide a disincentive for responsible spending and health insurance rate containment. We should not, as a matter of public policy, contribute to the erosion of job opportunities for Americans and encourage health insurance costs to go up even further by enacting employer mandates.

Another concern NAHU has with employer mandate proposals is that most come with an opportunity for employers to "opt out" of providing coverage themselves, and instead pay into a government-sponsored plan or fund that would provide coverage to uninsured workers. Often termed a "pay or play" approach to mandating coverage, NAHU finds this approach objectionable for many reasons. In addition to our concerns about the employer-mandate component to such an approach, NAHU also opposes government-sponsored plans to provide coverage that could more adequately be provided by the private market. Other countries' experiences with government-run health insurance plans clearly show that because of their global budgeting process, they often have to deny care to those who may need it most through a system of rationing. In addition, the most up-to-date medical technologies may not be available either because there is literally not adequate equipment or because they can't afford to run the equipment they have. Often these systems shortchange physicians and other health care providers. In our country, Maine's current extremely costly experience with attempting to provide a government-sponsored plan for employers that competes with the private market through its Dirigo Choice program clearly shows that such plans contain hidden administrative costs that have a negative impact on the quality of patient care and coverage.

Medicare for All

While discussing government-run health care, it seems appropriate to address the several current legislative proposals that would expand access to Medicare to all Americans. Under each of these proposals currently under consideration, all Americans would have access to the same coverage that now covers our senior population, or a choice of a plan through the Federal

Employee Benefit Program (FEHBP). It should be noted that the cost of this type of proposal is extremely high, well beyond the scope of affordability.

But beyond that issue, even though we do not currently experience rationing in our Medicare program and seniors in most areas have a broad choice of providers and access to technology, the cost for expanding Medicare or FEHBP nationwide would absolutely require a global budget, even if accompanied by an employer mandate, an individual mandate, a tax increase, or all three. It would, in fact, be fiscally irresponsible to operate a program of that magnitude without projections and limits on spending. Our Medicare and Medicaid programs already constitute the largest health plans in the world and the Medicare Trust Fund is already expected to become insolvent in 2015. The thought of expanding this already troubled program without a global budget is not logical. And we've seen what a global budget has produced in other countries. We don't believe this is what the American public wants. In the richest country in the world, we should look to our private sector for solutions.

In addition to our concerns about financing, NAHU also has concerns about applying facets of Medicare's overall operations to the entire marketplace. By statute Medicare fixes prices. Generally, it does not negotiate with providers, and the program really does not make distinction for price, volume or quality. The amount of payments made under the Medicare program is a subject of constant Congressional and public debate, and this problem will only worsen if the covered population were to be expanded. In addition, coverage under Medicare is necessarily limited in scope and includes far fewer benefits than the average group health insurance policy held by the majority of Americans. Changes to Medicare's core benefits involve Congressional action and/or the federal regulatory process, which makes the program ill-equipped to quickly respond to changing consumer needs and medical best practices. While the program is designed to work with some type of private market supplement, and private market supplementation would certainly still be required under any potential expansion of Medicare, supplemental benefits are also highly regulated. It is our feeling that the majority of American health care consumers, who value choice and options above all, would in the long run be highly dissatisfied by such an expansion.

Individual Mandates

Another one of the proposed universal-coverage solutions often discussed is an individual mandate for insurance coverage. An individual mandate requires each citizen to have some type of health insurance coverage or face a penalty. Massachusetts became the first state to enact individual-mandate legislation in 2006, and the idea is currently receiving bipartisan attention in many other states and at the federal level.

NAHU feels that imposing an individual mandate that utilizes the private market is certainly an outside-of-the-box approach to reducing the number of uninsured Americans. This idea assumes people will take personal responsibility for their health care utilization and would help reduce the amount of "charity care" provided for the uninsured in this country through emergency rooms and other means, the cost of which is ultimately shifted to the private health insurance market. Often individual-mandate proposals are associated with a move away from employer-sponsored coverage, but they need not take that direction. A mandate to require individuals to carry coverage could allow coverage to be obtained in a variety of settings, including through an employer-sponsored plan.

However, the idea of an individual mandate does raise many questions and concerns that will need to be addressed, particularly in states where the health insurance regulatory environment is much different than the regulatory climate in Massachusetts. For example, will imposing an individual mandate do anything to reduce the rising costs of providing health care, and thereby the costs of providing insurance? Massachusetts still has some of the highest health insurance premiums in the nation, largely because the new program was put in place without addressing inappropriate regulations that were already in effect at the time its mandate was enacted.

Mechanics of an Individual Mandate—Access to Coverage and Impact on the Existing Individual Market

In order for an individual health insurance mandate to work, all people in the jurisdiction with the mandate must have equal access to health insurance coverage, including those purchasing coverage in the individual market. In Massachusetts, access to coverage is not an issue because state law already mandated that all health insurance coverage be issued on a guaranteed basis,

which means that no individual can be denied coverage based on any type of preexisting medical condition. Federal law mandates that health insurance coverage be issued on a guaranteed basis to small-employer groups, but there is no such federal individual or large-group mandate. In the majority of states, traditional individual health insurance is not issued on a guaranteed basis, so people can be turned down for coverage due to a preexisting medical condition to prevent adverse selection.

Although this sounds unfair, the ability to ask health questions of individual market applicants keeps the cost of coverage down for most people who purchase coverage. And even though they are not required to do so, most states have developed some way to provide uninsurable people with access to individual health insurance coverage. However, the way the majority of states provide for coverage for people with catastrophic medical conditions seeking individual market health insurance coverage is very different than in Massachusetts, and this way is not as easily aligned with an individual mandate. Thirty-three states provide coverage to medically uninsurable people through high-risk pools, which allow the costs for less healthy purchasers to be handled in a way that does not impact the cost of coverage for the majority of people who buy coverage in the individual market, and six others use a similar private mechanism known as a "carrier of last resort." The reason these states have gone a different route than Massachusetts is that the "guaranteed-issue" route has been found time and time again to raise individual health insurance rates, as it provides individuals with little incentive to purchase coverage unless they anticipate that they will need the benefit. [2]

Therefore, in most states an individual mandate would require some study as it relates to current laws and regulations. Additionally, high-risk pools would have to reassess their financing mechanism to allow for increased enrollment, perhaps through increased federal funding. Also, it is important to note that five states currently have no means at all of providing individual health insurance access to people with catastrophic medical conditions,

[2] High-risk pools offer comprehensive private-market coverage options that might not otherwise be available to individuals who have ongoing health conditions and do not have access to employer sponsored coverage. These individuals pay higher rates than other individual market consumers, but these rates are capped, generally at about 125-200 percent of the average individual market rate. Because rates are capped, and because the individuals that utilize the pool often have the highest possible loss ratios, premiums alone would never be sufficient to satisfy claims. Therefore, the 33 states that have created high-risk pools to serve their individual health insurance markets have also established additional funding mechanisms to offset pool losses.

and so the means of providing access to coverage in these states would have to be addressed on an immediate basis. Imposing an individual mandate in these states would be next to impossible without significant individual market restructuring.

Some may say that a simple way to address the issue posed by not having a guaranteed-issue and or community-rated individual market would be to change each state's individual health insurance regulatory structure so these measures exist. However, NAHU has observed that, in all states with guaranteed issue and the community-rating or modified-community-rating mechanisms, younger, healthier individuals and workers are penalized because insurance carriers cannot account accurately for these healthy risks. This causes much higher overall health insurance rates than in the states that allow for the use of underwriting based on insurable risk. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which limits consumer choice, reduces competition and leads to overall higher prices. An important goal of an individual mandate is to improve access and expand coverage in a state. Care would need to be taken to ensure that the market reforms needed to implement the mandate did not inadvertently create cost increases.

Subsidies

Price is the number-one reason Americans go uninsured. Seventy-one percent of the non-elderly uninsured and 97.5 percent of the non-elderly uninsured who go without coverage for more than one year indicate cost as the driving factor for their lack of coverage.[3] As such, if there is a mandate that individuals purchase health insurance coverage, then there will also need to be some type of assistance to those who cannot afford to purchase coverage independently.

A system of determining subsidy eligibility would need to be determined, as well a system of verifying that beneficiaries actually have the income limitations and meet the other criteria necessary to qualify for benefits. The example of TennCare, where Tennessee was spending $30 million to $40 million per year on ineligible enrollees during the height of the uninsured subsidy

[3] Congressional Budget Office. "How Many People Lack Health Insurance and for How Long?" May 2003. www.cbo.gov/showdoc.cfm?index=4210

program -- which nearly bankrupted the state -- shows why this step is necessary. Also, it will be important to address how to prevent "crowd-out," which occurs when individuals who actually have eligibility to obtain private employer-sponsored health insurance enroll in the public program instead.

Finally, in addition to the issues of the cost and structure of subsidies, an issue that needs to be addressed is how to encourage people to take advantage of the subsidized-coverage opportunities already being made available to them. Despite the free or subsidized health care programs available to many Americans, studies have shown that less than 50 percent actually participate. The federal government currently has a variety of large- and small-scale programs and measures in place to provide individuals with access to health insurance coverage, and we spend upwards of $99 billion per year to provide care for the uninsured[4] but many still don't participate. Research estimates that currently about half of eligible non-participants have private coverage and half are uninsured.

Penalties and Enforcement Issues

Any individual health insurance mandate must require the individuals seeking health care toobtain group health insurance through an employer or other means, purchase individual health insurance privately, or apply for the public health care assistance that is available. If the individual does not, the law must impose some form of penalty. The penalty and enforcement process, as well as the mechanism for certifying whether or not an individual actually has purchased the required coverage, all raise questions and concerns. In Massachusetts, the penalty, enforcement and certification process have all been attached to the state income tax. That mechanism has been widely suggested as a model for other states or the federal government. However, in nine states[5] there is either no income tax or no significant income tax; in these states, other methods would have to be utilized.

[4] Kaiser Family Foundation. *Daily Health Policy Report.* June 5, 2003. www.kaisernetwork.org

[5] Alaska, Florida, Nevada, South Dakota, Texas, Washington and Wyoming do not levy an individual income tax. New Hampshire and Tennessee only tax interest and dividend income.

Even if done strictly at the federal level, the income-tax method could prove to be problematic. First of all, millions of low-income individuals are exempt from state and federal taxes, so developing an enforcement mechanism for this target population is an issue. Another concern is that each year millions of Americans who should file tax returns do not, and millions more cheat on their income taxes or do not pay taxes owed. In 2003, the federal government admitted that Americans did not pay $311 billion in taxes owed.[6]

Would a state or federal income tax penalty even provide enough of a financial incentive to make people purchase coverage? The IRS indicates that the average federal refund amount for individuals is $2154[7], and state refund amounts are generally a fraction of the amount of a person's federal refund— far less than the cost of an individual health insurance policy.

How could health insurance coverage status be verified? Being uninsured to most individuals is a temporary situation. Just as many people spend some time during their lives as unemployed, many people go without health insurance for a short period. According to a Congressional Budget Office (CBO) study of the non-elderly population, approximately 45 percent of uninsured Americans go without coverage for four months or less.[8] So, depending on the time of year an individual was uninsured, the certification on an annually filed tax return could be inaccurate.

Finally, the most important consideration would be whether or not an individual mandate would lower the number of uninsured people in this country. State efforts to enforce an individual mandate for auto insurance provide an effective case study in this regard. In spite of car insurance mandates in 46 states and the District of Columbia, the Insurance Research Council released data in June of 2006 indicating that 14.6 percent of American motorists lacked car insurance in 2004. Even with a database to independently verify whether someone has the required insurance coverage, the percentage of uninsured motorists remains similar to the percentage of the population without health insurance.

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[6] CBS News. "IRS Pleads Poverty: Asks for Bigger Budget to Catch Cheats and Collect Billions Owed." August 4, 2004. www.cbsnews.com/stories/2004/08/04/politics/main633848.shtml

[7] Internal Revenue Service. *Tax Stats at a Glance.* www.irs.gov/taxstats/article/0,,id=102886,00.html

[8] Congressional Budget Office. "How Many People Lack Health Insurance and for How Long?" May 2003. www.cbo.gov/showdoc.cfm?index=4210

Conclusion

NAHU is extremely concerned about the problem of the uninsured and recognizes that there is no one solution to this massive societal problem. However, health insurance is expensive because of the high cost of health care. The driving factors impacting the cost of health care need to be addressed before any universal-access initiative could work. Solving the cost problem will require comprehensive solutions in order to benefit consumers, employers, providers and insurance carriers. NAHU believes competitive market forces will have the greatest positive impact on the cost of health care. Health care reforms need to build on the best aspects of the American health care system and unleash the creative power of a competitively driven marketplace.

Instead of an employer mandate and/or a state-sponsored fund or plan to pay for uninsured citizens, a more effective approach would be to address the real problem concerning health insurance coverage in America—rising health care costs. Rising costs are what is driving the increase in the number of uninsured Americans since they make it so difficult for both employers and individuals to purchase affordable health insurance products. Addressing this problem through market-based solutions, such as allowing the sale of varying products based on individual need, improving regulatory environments to make state health insurance markets more competitive, and providing tax credits and incentives so that more individuals and employers can afford to purchase coverage makes much more sense. Working with consumers to improve national wellness, raise awareness of health care pricing and reduction of unnecessary utilization of health care serviceswould also go a long way toward controlling health care cost increases.

I appreciate this opportunity to be here today and will be happy to answer any questions you have.

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Chairman CONRAD. Thank you very much. Thanks to all of the witnesses.

Let me ask you all the same question.

If you had the ability to design the system or at least take interim steps that would lead in the direction I think we would all like to go in terms of trying to get everyone covered, what would you do? Dr. Aaron? If you were given the power to design the system, what would you do?

Mr. AARON. I actually was asked that question just the other night. And I responded in light of the three problems that I described. The first thing I would do would be to try to secure enactment of some version of the three bills that have been introduced to put the Federal Government in the position of supporting State health care reform, one of which is cosponsored by Senator Graham, who just came in the room just now.

The reason I say that is that the objective circumstances across the United States as far as the delivery of health care reform, the financing of health care reform, the use of health care, are so diverse, so different, ranging from more than 25 percent of the people uninsured in Texas to well under 10 percent in much of New England and Minnesota and Hawaii. Health maintenance organizations dominating health care delivery in some States and not existing in others. Spending differences of 60 percent or 70 percent among the States, per capita spending differences.

I am skeptical that we know enough now to design a single system to encompass that range of diversity. So I think the first step is to get behind what strikes me as the palpable energy now in the States to move ahead with health care reform. I think it is going to be difficult to draft that kind of a bill but there is a lot of interest. The House bill now has 70 cosponsors, nearly equally divided between Republicans and Democrats.

I think you can make some progress here. Get the SCHIP bill debate behind you and then move on this.

The other two areas that I think are critically important relate more to quality and to the practice of medicine. We simply do not know what works and what does not for most of what physicians do. It has not been evaluated.

The history of Federal sponsorship of agencies to try to add to that knowledge is really a pretty dismal one. Short, ugly and brutal is the life expectancy of these various agencies. I think it is possible to create an agency and fund it that would be protected from the political winds that have knocked down the previous agencies. And we need to begin to buildup this body of medical knowledge on what works, what does not, what is cost-effective.

If you are a private insurer, if you are a business, if you are a labor union, and you want to impose some kind of constraint on access to care what evidence do you—can you refer to now?

Chairman CONRAD. What agency would you give that responsibility?

Mr. AARON. What I would like to see is an organization that was created independent of the current department structure with a governance structure similar to that that has worked so well for nearly 100 years to provide independent monetary policy, that of

the Federal Reserve, funded by an earmark or a charge that is not subject to annual appropriation.

The objective here would be to have an entity that was governed by people who could not be removed except for cause, who had staggered terms, lengthy terms, and a funding source vastly larger than those that have been discussed in the SCHIP reauthorization bill, to underwrite this kind of research. Until we have that kind of knowledge, I think it is going to be damned difficult to justify saying no to what may be relatively ineffectual or unnecessarily costly care. So that would be the second element.

The third element, I think, is we really do have to get serious about information technology. As I commented in my statement, President Bush created an agency headed by a very distinguished and capable civil servant, David Braylor, but the authorizing legislation said except no new money shall be appropriate for this agency.

It is going to take some additional Federal support to help the private medical sector reorganize itself, implement information technology, and move from the age where solo docs did it all and prided themselves on never pleading ignorance into a world where information demands are so vast that physicians and other providers have to work as teams and exchange information freely. That is a key step to boosting the quality of health care in the United States.

Chairman CONRAD. Very well. Thank you.

Dr. GLIED.

Ms. GLIED. I would second the approach of encouraging State variation. I think it is a good way to go for several reasons. We do not know the answers and we need to see how we can develop answers that will fit within the United States. There is tremendous variation across the country in spending. And everything that we do nationally creates cross-subsidies between low spending areas and high spending areas that are just unjustified, I think. So I enabling State variation in design and encouraging it at the Federal level is important.

Second, I think we need to consider tax code changes that would get the money to buy health insurance into the hands of the people who need it rather than spending it in the inefficient way that we do now. I think that can be an important step in conjunction with several different directions for reform.

And I think another thing that we need to do as we move ahead with state variation, which I think is the way that progress is perhaps most likely to be made, is to think about ways to allow the Federal Medicare program to benefit from savings and innovation that take place at the State level.

So we need to think about how to really—and that goes back to the question of variation among the States in spending levels already. How can we actually capture some of that saving that we might be able to get by bringing the high-cost regions down within our program.

I think comparative effectiveness research is critically important and I think information technology is very important. I do not think that they will have an enormous or direct impact on the cost of our health care system. I think over time, especially if the pro-

vider community really adopts the recommendations of these programs, they could have an effect on the quality of our health care system. We have not spoken enough, I think, about how poor the quality of our health care system actually is but that is a really important direction for us to go in.

Chairman CONRAD. Ms. Trautwein?

Ms. TRAUTWEIN. Not to be repetitive, but I actually would agree in part with the other two panelists relative to the State issue. But I would say that we need to proceed with caution in that area and here is why.

When I talked earlier about Massachusetts still having some of the highest costs in the country, there is a very important reason why that happened. I do have concern about very creative State ideas like Massachusetts's program being done before important basic reforms are done. Massachusetts should have changed some of their current regulatory structure before they proceeded with what they did and they might have had quite a different result than they did.

So I agree that we need to look at the State side but we need to do so with certain parameters in mind to make sure that States have not already foiled themselves before you even get there with the creative ideas. We do not want to be a Band-aid, in other words.

I also think one of the reasons why it is very important to look at the state level is we do have a very different picture from State to State, not just because of the regulatory environment but also because of the whole issue of rural health care. Rural health care has all sorts of issues, provider access issues, but it also has an important cost issue. Because of the fewer number of providers that are there the costs of providing care are significantly higher in those areas, not to mention lack of access to important technologies that prevent people from being as healthy as they otherwise might have.

The other thing, I do think we do need to provide incentives for employers to offer coverage. We need to provide incentives for people and subsidies for people who cannot, who genuinely cannot afford to pay for coverage on their own. We must get these people in the system. We just need to proceed with caution in how we do it.

We also need to make sure that we are not instilling waste into the system with frivolous lawsuits. There are a lot of different ways to approach this. The Senate has looked at medical liability many, many times. I think there are other ideas we have not addressed fully enough to address the problem. We do not have to just introduce the same idea over and over and over again, but let us not forget that there is a problem.

And finally, this whole issue of information technology, we have experienced that in my own family where we have seen duplicate tests, having to do things over and over again because one doctor was not able to talk to the other one. It is a horrible waste of money. We have to do something and move forward with that. That is a bipartisan idea and we should waste no time in getting that done.

Chairman CONRAD. Thank you, very much. Senator Allard.

Senator ALLARD. Thank you, Mr. Chairman.

I like the approach that a couple of the witnesses have talked about where you use the States as a laboratory to begin to put some of these ideas into action. Ms. Trautwein, is that right? You keep talking about needing to look at the regulatory structure. What are you seeing in Massachusetts and other States where the regulatory structure has to be changed in order to have an individual mandate on health insurance?

Ms. TRAUTWEIN. If we had looked at a State like Massachusetts—and there are others—many of them are concentrated on the East Coast. They have the worst situations there, cost-wise. They have a few things in common.

No. 1, their market is much more tightly regulated in terms of the ability to actually assess insurance risk. For example, in the individual health insurance market you can ask no questions at all. And the rate bands are very, very tight. What that means is that——

Senator ALLARD. Let me understand. In the health insurance market you cannot ask any questions at all? Who would ask the questions?

Ms. TRAUTWEIN. The insurance companies.

Senator ALLARD. Explain that to me.

Ms. TRAUTWEIN. The insurance companies who provide the insurance. The same as if you applied for auto insurance, they ask you for your driving record. The same thing happens in the individual health insurance markets in almost every State.

If you compare the costs for coverage in States that are allowed to do that and the cost of coverage in Massachusetts or Maine or New York or New Jersey or Vermont, you will see that they are very, very different. Most states have provided a vehicle for those who do not pass the health questions, who do not pass the medical underwriting, so that they can still get coverage at an affordable cost. That is just an example of one thing.

The other thing that is very important—there there are numerous things. But the other thing that is really important is the way rates are established. Too tight of a community rate, so that everyone is paying the costs——

Senator ALLARD. You have smaller pools.

Ms. TRAUTWEIN. Yes, smaller pools. And the younger people really just, because they think they are invincible, choose not to pay the cost. It is a great deal if you are 55. But if you are 25, it is not. And those are the people that we need in the system to keep the costs down.

Senator ALLARD. I have run across a company or an insurer—I will just put it this way—an insurer, that manages their health costs by keeping track of a doctor's diagnosis and then keeps track of the ultimate outcome of that disease when it is treated.

What they found is on some diseases—we could take diabetes as an example—when the diagnosis is made, some doctors get that patient stabilized in a shorter period of time than others. Some get a few days, some take weeks.

What they do that what they have found is that they go to the—they put the pressure on the doctor. They say look, your history tells us it takes you longer to cure your patients with this disease

compared to this other doctor. What is it that you could do to shorten the time period on that?

I need the docs do not like that but there are some variables. But how practical is that?

That is the only system where I have seen where you have increased quality and you have had the potential of holding down costs.

So how can a State implement something like this if they have an individual mandate? Anybody have any ideas on that?

Ms. TRAUTWEIN. I love that idea and we wish that more insurers could get their providers to participate in that. Again, it is a matter of a provider being able to say I do not want to be in your network and they can be an out of network doctor and they do not have to do anything like that. And so if we can get more providers to participate in things like that, it would be great. It would save a lot of cost in the system and it would be better for patients.

The other issue is how do we get the patients to choose those providers?

Senator ALLARD. The only ones that who have the ability is the bill payer. They are the only ones that have the ability to force the doctors to do that. So instead of an individual mandate, maybe you look at a mandate on those who reimburse for the costs to do this. How practical would that be?

Ms. TRAUTWEIN. I think most insurers would like to use some form of that anyway. But the issue is still, and I go back to the providers because we do not have any law that says Dr. Jones must participate in insurance company ABC's plan. They can say you know, I do not like your rules and I do not want to be in your plan. I am just going to assume that my patients will like me enough to continue to come to me anyway because I do not like your silly rules.

A lot of them—we hear that a lot from providers. So that is the pushback that insurers are hearing from their provider network as they try to impose more and more. I am not saying we do not think it should be done and that a lot of them are not trying it. It is just that the reality is that we are hearing reports of provider pushback.

Senator ALLARD. I see my time has expired, Mr. Chairman.

Chairman CONRAD. I thank the Senator.

Senator WYDEN.

Senator WYDEN. Thank you, Mr. Chairman, an excellent panel.

Dr. Aaron, I share your view about how important it is to give the States a major role in designing the health system, and we do that in the Healthy Americans Act. We have very broad waiver provisions so they can, in effect, go off and do their own thing by getting close to essentially what the Healthy Americans Act calls for.

But I would like your thoughts on the developments this year because, as you characterized it, there was palpable energy at the State level. Every single State legislature met in 2007 and not one of them, not one, passed a major reform bill. California is still out. We are all keeping our fingers crossed and hope they do it.

My sense is the reason it is so hard for the States is that they cannot get their arms around any of the big drivers in American

health care. They cannot get at the Federal tax code. It cannot get at Medicare. They cannot get at ERISA. Veterans is a Federal program.

In fact, I am going to say, and I talked a little bit with Senator Graham, I think we ought to be saying three cheers for the States because they are getting a lot done given the fact they have virtually no bandwidth in which to work in.

What are your thoughts specifically about why nobody at the State level was able to move in 2007 when there was all this energy this year?

Mr. AARON. First, I think there is still some possibility for State action. Notably, there is a current dustup between the administration in New York over pushing the SCHIP limit up rather considerably. There is a lot of energy to do similar things with SCHIP in other States as well. So I think there is a little more possibility for positive action.

The States, though, face some very serious obstacles. One is the restrictions, the Federal regulations imposed within discrete programs. A second is that they, like everybody else, face competing demands for available resources. The reason there is so much proposal activity at the current time is that the States are unusually flush because of rising tax revenues.

You have mentioned ERISA. That is, I think, a serious impediment since it puts self-insured health plans pretty much off-limits.

There is another obstacle which I do not think hasten sufficient attention actually from any of the bills that would push State action, and that is it the cyclical threat that if you over commit when things are—when the economy is favorable, you may be left holding a financial day of very considerable girth when the economy turns sour.

I think one step that could make it much more attractive for States to move ahead and make commitments is if any Federal legislation that provides encouragement to State action along the lines of the three major bills that have been tabled also contains a provision that provides automatically on a formula basis some financial support. Not completely bailout, but some financial support during recession periods.

Senator WYDEN. Let me see if I can get one last question in because in many of these debates, and particularly Lindsey and others, talking about the States—and I want to be clear, I am supportive of the role of the States—they are saying there are no models. Gosh, we ought to have a model.

I will tell you, there is a model, folks, in this country and it is in my wallet. This is a private insurance card that covers the Wyden family. And there are a couple of twins that are arriving here in a few weeks, so we been a lot of attention to this private insurance card.

When you come to one of my town meetings, and I bet it happens for Bernie and all of us, what folks say when you ask them about health care they say we want coverage like you people have in Congress. Folks are not completely sure what that is, but whatever it is we have, they would like. That is sort of the story.

So after I spent these 4 years on this policy and this effort to try to come up with a plan, I said what is wrong with the basic model

Members of Congress have? We recognize it is different. We would be the first to say it is different.

But what happens is Senator Graham, I, all of us, we get information during the open enrollment system. They give us choices of private coverage.

Under the Lewin analysis, they said our administrative costs would be about 3.4 4 percent. So we are talking about really driving down the administrative costs when you use the big pooling arrangement that I and Senator Gregg and Senator Bennett and all of us are talking about.

Folks, what is wrong with that as a model? We have it today. It is not something you have to go out and reinvent. Why not try to figure out a way, recognizing that it would have to be different? I'm not saying that the Members of Congress system is exactly analogous.

But what is wrong with a model that says during open enrollment season you get information about private choices. You fix the private market so the private insurance companies cannot cherry pick and just take healthy people. You have a place for people to go for their questions. You drive down the administrative costs like Lewin says we are doing. What is wrong with that as a model? Professor Glied?

Ms. GLIED. I do not think anything is wrong that as a model. I think it is a perfectly reasonable model. I guess there are some questions about how you put it together. And particularly how you make it more regional rather than having it run out of Washington, out of OPM. There is a lot of work to be done to make a model like that operate. And there are lots of questions about what happens to people who already have coverage through their employers. Is everybody going into that FEHBP? Or are we going to have parallel structures? And what are the issues that are going to come out of that?

I think there are better and worse ways to design a plan around that, but I think it is an excellent basis.

Senator WYDEN. I am going to quit while I am ahead and you have given me extra time, Mr. Chairman. Thank you.

Chairman CONRAD. Let me just say, if we are going to be doing this based on the American people wanting our health care system, I saw a poll that was taken not so long ago that the American people think all senators live in mansions, that we have servants, and that we are chauffeured in limousines.

I drew this to the attention of my wife, who was highly amused by this since I drive a 1999 Buick, we live in an 1,800 square foot house, and the servants in our household are Kent and Lucy. Lucy is my wife.

[Laughter.]

Chairman CONRAD. Senator Graham.

Senator GRAHAM. And there is Senator Grassley in 1960-something.

But anyway, Dr. Aaron, about the bill that we are try to come up with? Can you explain it? Because I know you will do better than I would do? What are we trying to do, me and Senator Feingold?

Mr. AARON. I think what do you and Senators Bingaman and Voinovich and in the House, Tammy Baldwin and Representative Price from Georgia, are all trying to do has certain structural similarities. In each case, you would create a bipartisan federally sponsored entity D to receive and to review proposals from States with firm goals and specific procedures for extending health insurance coverage.

The bills differ in the exact ways in which this agency would it be created. They differ in the ways in which or whether additional funding would be provided to those States whose plans are approved. The commission would be structured so that there could be confidence on both sides of the aisle that both conservative and liberal proposals from different States would be approved. For example, you have balanced appointment to this committee and you require a super majority to send a forward a proposal. So both Republicans and Democrats would have to approve a roster of State proposals.

Congress, under expedited procedures, would either approve or reject the whole lot, sort of a fast-track approach. The programs would run a typically for approximately 5 years, during which period the States would report back to the commission on the progress that they are making or not making in extending health insurance coverage.

The idea is to facilitate the proposals, which, as Senator Wyden has correctly observed, have not been rushing through legislatively in this calendar year to try and achieve a better outcome in future years.

Actually, States have taken a number of steps previously, not all of which have succeeded and many of which have not endured because of fiscal cycle reasons, to extend health insurance coverage. I think the philosophy behind this is when one is talking about national health reform, one is talking about a nation in which the objective differences among the States are at least as great as they are among the nations of the European Union. And that it may well be more possible within the narrower confines of State offices to negotiate the difficult compromises that need to be made in order to field a comprehensive proposal.

The poster child for this now is Massachusetts. Everybody is watching to see whether they will successfully deal with the problems they are unquestionably encountering. Right now I think the auguries are favorable. Diverse groups are still working together.

And the purpose of your bill and the other two bills, and now I should say three because of Senator Sanders' and Congressman Tierney's bill, is to encourage those efforts by providing a little regulatory wiggle room, possibly some additional funding, and national support.

Senator GRAHAM. I am really impressed with myself after hearing that.

[Laughter.]

Chairman CONRAD. Among our colleagues, there is almost no restriction on the ability to be impressed with ourselves.

[Laughter.]

Senator GRAHAM. I have taken it to a new level here.

One thing, and my time is up, is there any country out there that you would point to as having gotten it particularly right?

And the second question is one of the big issues we face in this country is the cost of dying. When you discuss health care and prevention, you also have to talk about how much money is spent in the last illness preceding death. Any thoughts about what we could do along those lines?

Mr. AARON. On the first point, the World Health Organization has evaluated health care systems of different nations. The top award went to France. A former Assistant Secretary of Health said to me, and he is obviously a person who can get access to the best that the United States has to offer, that if he were to get sick anywhere else in the world, France would be his choice about where to get sick.

That said, I do not think it is important. I think each nation has its own unique history, its own unique political setting, its own objective circumstances that differ. We each have to find our own ways.

As for the cost of dying, I think the high cost is certainly real. It sometimes is exaggerated. The proportion of health care spending that does occur during the last year of life is under 20 percent. And it is important to recognize we do not know at the beginning of that year that it is the last year of life. A lot of the people who receive health care continue to live on beyond that period, for which we should be thankful.

But I do think it is important for physicians and families to face up to the fact that, as one English person once said to me, Americans erroneously believe that death is an option——

[Laughter.]

Mr. AARON [continuing]. And approach it in that fashion. As I age, this is a topic that is increasingly on my mind, I must say.

Chairman CONRAD. I thank the Senator.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Chairman CONRAD. Let we just stop you if I can. There is going to be a moment of silence observed on the Senate floor at noon for the victims of 9/11. So my intention is to wrap up about 5 minutes before.

So I am going to try to be pretty strict with respect to the 5-minute time so that we can conclude this before the moment of silence to be recognized. Senator Whitehouse.

Senator WHITEHOUSE. In that event, let me ask a very narrow and targeted question in this great big issue that we have been discussing, and that is in this area, in which improved quality of care provides lower costs—and it does not always do that but there are identifiable areas that can be found where when you improve the quality of care it does lower the cost.

And it strikes me that that is an area that we should be mining incredibly diligently for those savings and for those quality improvements. Everyone should be behind this. This is not an I win/you lose political fight between two interests. This is just making it work better at less expensive and save lives. And it is not happening. It really truly is not happening to anywhere near the degree that it should be.

There is some kind of a market failure out there that is preventing this from happening despite everybody's interest in having it get done. What is that market failure? Why is this not happening more?

Ms. GLIED. I think the reason it is not happening more has to do with the way that payments are fragmented. So in total a lot of those things save us money. Improving quality saves money in terms of infection control, for example. But it does not necessarily save hospitals money. Or when it saves hospitals money, it does not necessarily save insurance companies money or it does not save physicians money.

And the way that money flows in our system in the fragmented way it does, it is very difficult to make deals that make everybody better off. It is one of the things we really should be looking out for.

Senator WHITEHOUSE. If you were to try to pursue those deals that you just mentioned, where people have the chance to get together and work them out so that we can explore those areas, would that more likely happen effectively at the local level or dictated by the Federal level?

Ms. GLIED. My sense is that most of those changes have to happen at a local level. And if the change has to happen at a local level, it is probably best to try and implement it as close to the change as you can, that it is actually more difficult to try and do it nationally. It is better for groups of doctors, hospitals, and insurers to sit together somewhere and say we are going to tackle this problem here.

Senator WHITEHOUSE. Plus, they are bumping into each other all the time on all sorts of issues locally, so there is more honor, if you will, in the negotiations.

Ms. GLIED. The difficulty with health care is that it is, ultimately, a locally delivered commodity. And we need to recognize that at every step along the way. Mr. Aaron.

Senator WHITEHOUSE. I see, I think, three heads nodding approval. But in my last minute or so, do you both agree with the exchange we have just had?

Ms. TRAUTWEIN. Yes, absolutely.

Mr. AARON. Yes, with modification that I think information is fresh air that helps. And in this case——

Senator WHITEHOUSE. Do not get me started on information technology.

Mr. AARON. No, no, I'm talking about data on health outcomes. It is very difficult to gather that from a million fragmented payers. That is a real advantage, for example, of the Medicare system which has vast quantities of data which have been underutilized to date. So the Nation can provide information that will help the locals do their job.

Senator WHITEHOUSE. Excellent point. And like Senator Wyden, I will quit while I am ahead and yield the remainder of my time.

Chairman CONRAD. Senator Sanders.

Senator SANDERS. Thank you very much, Mr. Chairman.

I just want to touch on a few points and then ask our panelists a question. We talk about universal coverage. Universal coverage saves us money and deals with human suffering because right now

in this country there are people who, when they get sick, do not go to a doctor until they are quite ill. And the insanity is that we spend zillions of dollars in hospital care when we could have saved money, saved human suffering, if they could have walked into the doctor originally when they were very ill.

No. 2, I know that in the Congress it is customary to demonize "government health care." We have a president who does that every single day. And I find it very ironic, Mr. Chairman—I am a member of the Veterans' Committee—that we have Jim Nicholson, who is the former Chairman of the Republican Party, I believe, now head of the VA, coming before the Committee saying studies show that the Veteran's Administration has the highest quality health care of any major system in the United States of America. Let me suggest this is a socialized health care system, 100 percent government run, former Chairman of the Republican Party tells us how cost-effective and high-quality that care is.

Third point, in my State and around this country, and I know in North Dakota, and I am working on this issue a whole lot, federally Qualified Health Centers are doing an extraordinarily good job in a cost-effective way of providing health care to every man, woman, and child in the served area.

I am happy to say thank you, Mr. Chairman, that with a little bit of luck we are going to significantly increase funding for FQHCs and expand them throughout this country.

Let me touch on another issue. And that is you can have everybody having insurance, but sometimes we miss another point. But you can have all the insurance in the world and you may not, if you live in a rural area in Vermont, have access to doctors. You may have a nursing shortage. You may have a major dental crisis.

So here is an issue that I would like some comments on. How is it that in this great country today we have a doctor shortage, especially among primary health care physicians in rural areas? We have a major nursing crisis, by which 50,000 eligible applicants for nursing school cannot get into nursing school but we are depleting the Philippines of their nurses by bringing them over here. We have an embarrassment in my State and all over this country. We do not have enough dentists.

I think one of my the solutions, Mr. Chairman, is to significantly increase funding for the National Health Service Corps.

By the way, the recent educational reconciliation bill will debt forgiveness, a big deal, for doctors and dentists and nurses and so forth.

But I would like maybe are panelists, starting with Dr. Aaron, to talk about how it can be that in America we have a doctor shortage, a nursing shortage, a dentist shortage?

Mr. AARON. I think we have a mixed problem currently. He has been remarked by many for some years that the incentives to specialize and subspecialize financially are extremely seductive. If you can make a mid-six-figure income in Chicago, it takes an awful lot of environmental compensation to have a five-figure income in rural Vermont.

Ms. GLIED. Unfortunately, I think one of the things that we have done with our health care system is let providers decide how many of them there ought to be. The number of new entrants into Amer-

ican medical schools, I think, stopped growing in the mid-1980's. The medical schools simply do not take any more medical students. The dental schools have also been very strict in terms of allowing increases in the number of dentists.

Senator SANDERS. They have a strong unit there——

Ms. GLIED. We effectively have a very strong union there. So we have created a shortage of our own design. And several other countries have done similarly. But we have a very low physician-to-population ratio compared to international standards.

Senator SANDERS. And am I right in assuming as we age that problem becomes more severe?

Ms. GLIED. Unless we do something about it, yes.

Senator SANDERS. What is your suggestion? Give me some concrete ideas as to how we can increase—especially, as Dr. Aaron said, I do not know that we need any more specialists in Chicago or New York City. But we do need obstetricians and primary health care physicians in rural America.

Ms. GLIED. I think we do need to do a lot of thinking about our provider situation. I do not think we need physicians for all of these purposes either. I mean, we have been very strict about who does what. But in many of these cases, nurse practitioners and other well-trained but less costly providers could be doing the job. We do not let them in many cases because our regulatory structures do not permit it.

I think there is a lot of scope for evaluating the regulation of providers.

Senator SANDERS. Now dental care is an issue, I think, that does not get enough attention. But are you suggesting that it is the dental schools that are playing a major role in determining how many dentists we have?

Ms. GLIED. Yes.

Senator SANDERS. Did you want to add something?

Ms. TRAUTWEIN. Basically I just want to agree with the other two. And having a son that is a premed student, the incentives to specialize are incredible. So we have to figure out how to provide better incentives for people to go into rural areas and to train in primary care.

And also, we have to figure out a way to train more of them. Whether it is dentists, whether it is nurses or whether it is physicians, there are not enough slots for the people that want to——

Senator SANDERS. I do not want to start a major controversy. I see, fortunately, Senator Gregg is not here. But Michael Moore's movie makes the point that in Cuba they are sending doctors all over the world. They are able to train far more than they need. And in this country, we are not training enough physicians.

Your point is a good point. Some way or another we are going to have to provide incentives to get physicians, young people, into medical cool school, into dental school, to get out to those areas that we need them, not just in big cities where they can make a whole lot of money.

Mr. AARON. Let me just add here the point that Professor Glied made. You put a nurse practitioner in a rural area, connected well to specialists located someplace else, and you can get very high-quality care.

Senator SANDERS. Thank you very much, Mr. Chairman.

Chairman CONRAD. I thank the Senator.

Senator CARDIN.

Senator CARDIN. Thank you, Mr. Chairman. And thank you for holding this hearing. And I thank our panelists.

I tell the people of Maryland, when we talk about the health care debate and universal coverage, that I am a survivor. By that I mean I voted for, not only supported the Clinton proposal back in 1993, I voted for it on the Ways and Means Committee Subcommittee on Health. And I am still in Congress.

Mr. AARON. But not in the House.

[Laughter.]

Senator CARDIN. That may have been the penalty, I had to come over to the Senate.

Chairman CONRAD. Let me tell you, that is not a penalty.

Senator CARDIN. I even got promoted.

What I learned from that experience is that in 1993 the majority of the people in this country supported universal coverage. And it was a popular thing we thought was going to happen. But when we started to get down into the details as to government's responsibility and employers' responsibility, we lost the critical mass necessary to pass universal coverage.

I think universal coverage is critically important for so many reasons. We talked about cost. If you're going to have a cost-effective system, everybody's got to play according to the same rules. You need universal coverage if you want efficiency in the system. We have to have everyone covered so we can have the right facilities in the right location.

And just from a humanity point of view, we have great health care in America. The problem is too many people are not able to get that health care. And the fact that they are uninsured is one of the leading reasons why so many people are denied necessary health care.

So I have come to the conclusion that we need to find a way to get this done.

I have introduced legislation, Mr. Chairman, that is four pages long. It is an individual mandate. It is pretty simple. It just says everybody has to have health insurance. It then allows the States not only the responsibility to determine what is adequate health insurance but requires the States to have at least three low-cost plans available on community rating so that there is a product available in each of our States to those who need to be covered who are not covered by their employer or under governmental programs.

The enforcement is kind of simple. It may not be totally effective. We may not get 99 percent coverage. But we certainly would get a lot more coverage than we have today. It is enforced under our Federal Internal Revenue Code which is, of course, applicable in all States. And one of the criticisms about individual mandates in States that do not have income tax is how you enforce it.

Now, I want to make this clear, Mr. Chairman. I think that is the beginning of the debate, not the end of the debate. That if we had an individual mandate, then we could, I think, talk about what is the appropriate responsibility of employers in America in meet-

ing the needs of all of us who need and have health insurance? I think it talks about what is individual responsibility, not just financially to buy health insurance but as consumers to purchase health services in this country? What do we mean by coverage? What is adequate coverage? What should be included in health plans in America on wellness or mental health parity and affordability? What should be the responsibility of individuals? And how do we bring the costs down? And then federalism. What is the Federal Government's responsibility? What is the local government's and the private sector?

I think all of that would be on a healthier plane if we at least start with the mandate that everyone must have health coverage in America.

So I thought I would use my 5 minutes to try to promote support for my proposal. Any takers among the panel?

Mr. AARON. I think you are going to need more than four pages before you have a proposal that——

Senator CARDIN. Of course, in the Senate you have unlimited amendments so I assume it will get longer than four pages.

Mr. AARON. When it does, come back to me please.

Senator CARDIN. That was not a ringing endorsement, Dr. Aaron.

Mr. AARON. Before you were here, Professor Glied listed a number of approaches, among which an individual mandate was one of the approaches to extending coverage, and I think validly indicated that using each could combine into an effective strategy for increasing——

Senator CARDIN. Of course, just to——

Mr. AARON. You can do it better than I can.

Senator CARDIN. Of course, one of the problems when you look at an individual mandate as the solution, it tends to be as long as Massachusetts, the bill. And I am trying to keep this simple because it is not the end of the debate but the beginning of the debate.

Ms. GLIED. It is a little hard to speak about something in that much abstraction. I commend you for moving ahead with something and I think a mandate—stating that we think it is a principle that everyone should have insurance is a clear step forward. I think the question is how are you going to actually make it happen?

Senator CARDIN. Let me be clear that my bill is to just a principle. It is a requirement.

Ms. GLIED. Right.

Senator CARDIN. And it is enforceable but not the end of the debate.

I want more from employers and I want more from government.

Mr. AARON. An individual mandate, again I am quoting my neighbor to my left here, is something—is effective if it is backed up by assistance to those who lack financial resources themselves so that it can become a reality. Otherwise it is just punishment.

So I think inevitably you are going to have to get into the tax code, into financing, into formulas for assistance. And that's going to stretch, unless the print is extremely small, beyond four pages.

Ms. TRAUTWEIN. I will comment on one specific aspect of your bill that you mentioned, and I had talked about this in my testimony earlier also.

I think all of us think that an individual mandate could work. But again the details, and part of that is the regulatory aspect, this issue about requiring a State to offer three basic policies. You would have to be very careful about how you structured that so that those policies did not end up being a dumping ground for you. Because if you went in and community rated those policies and the rest of their market was not community rated, it would end up getting the poorest risk. It would just need to be structured——

Senator CARDIN. Let me put out in Maryland we have a small market reform that is working. So there are ways that States can make it work if they want to make it work.

Thank you, Mr. Chairman.

Chairman CONRAD. I thank the Senator.

Senator STABENOW.

Senator STABENOW. Thank you, Mr. Chairman. And welcome, to our guests. I apologize for being late today because of the Finance Committee meeting. It certainly is not because of lack of interest because as all of us on this panel know, we are desperately and deeply concerned about this issue.

First, let me just put out a couple of points based on the discussion that I have been hearing. One is we talk about nursing shortage. I know specifically, as it relates to nursing, that our challenge is not having enough professors to train them. And so we have slots opening up, we are funding slots, but because of all of us baby boomers now that are retiring what I hear from very prestigious colleges of nursing is the problem is not having enough slots because we do not have enough professors to be able to really provide that. So in some way, we have to address that.

I want to thank the Chairman also for the federally Qualified Health Centers. Very, very important, very effective. Thank you for your help and leadership on that.

We really do have a universal health care system. But the reason it costs twice as much as any other country is it is called emergency rooms. And so people get treated sicker than they should be, inappropriately, where they could be in the doctors office. But they get treated. And then every business that has insurance or every individual picks up the costs.

That may have been said earlier, but that is my mantra consistently. It is not about whether or not we have it. It is how we want to pay for it and if we want to continue to pay this huge cost, very ineffectively.

A quick question. I am sure that Senator Whitehouse brought up health information technology. I would like to do that, as well. You spoke about local decisions earlier. I think, first of all, it is very difficult to have only local decisions when it is primarily federally funded as a system. We talk about we do not want a government-run system. Well, we are too late. Most of the funding is Federal or State or some public entity.

But health IT, it seems to me, brings that together where if we have that information available then local people can make good decisions within the context of a broad health IT system.

I know we talk about it in terms of cost all the time but you spoke about outcomes. This really is about quality. It is about whether or not you duplicate tests over and over again. Whether or not people have the right medicines and they do not conflict. Whether or not we are providing care in rural areas.

In the Upper Peninsula of Michigan we have a wonderful program that has been developed by Marquette General Hospital and their system so that they can put a nurse onsite out with somebody and through telecommunication be able to provide diagnosis and treatment, share x-rays, all of those things.

The VA is way out of us on all of this. The VA is doing an excellent job.

But I wonder if anyone would like to speak a little bit more to the question of sharing information and outreach and what that does in terms of quality. We know there is a cost savings but being able to look at more effectively particular diseases, chronic diseases, where they are, the ability to treat people through long distances and so on, diagnosis, sharing of information.

I do not know if anyone spoke earlier about that piece on quality. Because I think we are not good to get where we go if we are not rewarding investments in health IT and, in, fact incentivizing investments in health IT.

Mr. AARON. Actually, we did touch on those issues because, like you, I think all of us believe that those reforms hold out enormous promise for improving the quality of care.

Partly it is sending information to areas that may be thinly served by highly trained professionals so that people who are trained to a lower level can communicate with others who have that specialized knowledge.

Information on effectiveness can also help improve the quality of care in the highly served areas, as well. Not all providers are equally effective. Under the current system, as you suggested, I think a seriously ill patient may end up seeing a great many physicians who do not bother to talk to one another or do not communicate sufficiently well. So that it is important to facilitate communications even within well-served areas among various physicians.

So yes, yes, and yes to your suggestions.

Senator STABENOW. Anyone else?

Ms. GLIED. I think it is important when we talk about health IT to think about all the different forms that takes. And I think you emphasized communications, technology. I think sometimes we do not put enough emphasis on the kind of epidemiologic statistical data and the learning that we can get from that. That is a very different kind of investment than electronic medical records that might move from person to person. I think actually the epidemiologic data hold more promise even than the individual record.

Ms. TRAUTWEIN. I am not sure I have anything substantive to add, other than we do have to look at this both from a national, regional and local level. We need a national interoperable system so that we can exchange whatever information we need to of all these different types of information nationwide.

But we also need to look to customize that somewhat at the local level. Because we do, we talked about quality issues at the local level and how this is really a local issue and a local resource issue.

I think we need to make sure that we have a system that also can work for the very individual needs that those local communities have.

Senator STABENOW. Thank you, Mr. Chairman.

Chairman CONRAD. Thank you, Senator.

Let me thank this panel. I very much appreciate your taking the time to be here, share your thoughts with the Committee.

We are trying to provide some focus to this issue for our colleagues because of the critical impact on our Federal budget. We all understand that this is an area that can swamp the boat. It is the 800-pound gorilla.

I think we just need a lot more communicating, a lot more thinking about how we proceed to build consensus.

With that, I want to note that there will be a moment a silence on the Senate floor at 12 noon in memory of those who lost their lives and who were injured on 9/11.

So with that, we will declare the hearing adjourned and again thank our witnesses.

[Whereupon, at 11:51 a.m., the Committee was adjourned.]

Opening Statement of Senator Russell D. Feingold
Senate Budget Committee Hearing
Care and the Budget: Options for Achieving Universal Health Coverage
Tuesday, September 11, 2007, 10:00am

I thank the Chairman for holding this hearing today. I would also like to thank our witnesses for being here, in particular Dr. Henry Aaron from the Brookings Institution. Dr. Aaron is a respected voice in the health care policy community and I am pleased that he is here today to share his perspective. Chairman Conrad has already held hearings on the problems that we are facing in our country with respect to our health care system and the federal budget. As we all know, we have many problems with our health care system. It's expensive, it does not serve everyone, and the numbers of the uninsured continue to rise. Today, we are discussing how to best address these problems.

There are many different ideas for how best to fix the problems in the American health care system. They range from employer mandates to individual mandates and from consumer-driven plans to single-payer systems. I personally favor a single-payer system for our country; however, I recognize that a single-payer system is not going to be politically feasible in the near future. That is why I have introduced bipartisan legislation that proposes an approach that can move our country forward and get us out of the mire of dead-end political debates.

I have introduced the State-Based Health Care Reform Act with another Senator on this Committee, Lindsey Graham. This bill will give select states funding and authority to cover the uninsured within their state in whatever manner will work best in that state. There are minimal standards that states would have to reach, but states would have a great deal of flexibility in what approach to take. The bill avoids the current political impasse because it does not prejudge the type of reform that a state should adopt. Up to $40 billion would be made available for states to fund reforms, and this cost is entirely offset.

Senator Graham and I are from opposite ends of the political spectrum, we're from different areas of the country, and we have different views on health care. I personally do not support consumer-driven approaches or further privatization of the health care system, but these reforms are possible under my bill. States could also choose to create single-payer models or choose to expand public coverage to certain populations. These are approaches that I support—but they are not dictated in my legislation.

Senator Graham and I are not alone in our support of a state-based approach. Dr. Henry Aaron of the Brookings Institution and Dr. Stuart Butler of the Heritage Foundation originally wrote the paper proposing this type of approach. These are two economists from opposite ends of the political spectrum, yet they agree that this proposal is a viable way to achieve health care reform. The State-Based Health Care Reform Act is endorsed by Families USA, the Healthcare Leadership Council, SEIU, and the American College of Physicians. This is an idea that people from all different political backgrounds can get behind.

The bottom line is that something must be done, but there is no agreement on what that something is. We have 47 million uninsured in the United States and our health care costs are 4.3 times greater than our national defense spending and they continue to grow. Health care spending is expected to reach approximately 20% of our GDP by 2015. Our country cannot continue down this road much longer. We in Congress have an obligation to address these problems, and I hope that through debate such as that we are having today, we can come to an agreement on how we can move forward.

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